The Modern Hospital

MAY 1960

Juggling clowns give a sprightly touch to the lobby of Flatbush General Hospital, Brooklyn, N. Y. (page 86)

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The Modern Hospital

MAY 1960 VOLUME 94, NO. 5

Continued on next page ▶

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1. Taheri, Z. E.: Urevert in Cranial Trauma and Brain Surgery, J. Internatl. College of Surgeons 32:389 (Oct.) 1959.
2. Javid, M.: Urea—New Use of an Old Agent, Reduction of Intracranial and Intraocular Pressure, The Surgical Clinics of North America, Philadelphia, W. B. Saunders Company, Aug. 1958, p. 907.

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READER OPINION

Medical Staff Can Help With Specialists

Sirs:

The recent comprehensive review of the hospital-specialist question that appeared in your March issue of The MODERN HOSPITAL was superbly done and I am writing to commend you on the thoroughness with which the subject was covered.

As I look back over my years as a hospital administrator, I feel particularly fortunate in that I cannot recall any occasion wherein I had a serious problem with a hospital specialist in matters regarding reimbursement for services rendered to the hospital.

At the Woman's Hospital in New York City, the hospital specialists were all salaried. At St. Barnabus Hospital in Minneapolis the roentgenologist and his staff were on a percentage of the net income. The pathologist, who was on a salary, was changed on his request to a percentage of the net income; the physiatrist rented space in the hospital and operated his own department, and all of the anesthesiologists were on a straight fee-for-service basis.

At Presbyterian Hospital, and subsequently at Presbyterian-St. Luke's Hospital, Chicago, all of the hospital specialists were reimbursed on a salary basis, plus an annuity program. These financial arrangements were reviewed periodically and in all instances it was not difficult to reach an agreement.

The question of listing the names of the radiologists on the hospital invoice did come up for discussion and I referred this to the executive committee of the medical staff for a decision. Strangely enough, they discussed the problem over a three to four month period before finally giving their consent to have this done. I promptly complied with the request and, as new billheads were printed every eight to 12 months, changes were made to correct changes in the staff.

I can recall one occasion in Minneapolis when the roentgenologist and I disagreed on the amount that the percentage of net would return him. In my opinion the sum was equivalent to the average income of the successful practitioner in the community, and on this basis I considered it sufficient. When he objected to this position I suggested that we carry the matter to the executive committee of the medical staff for its opinion. As he considered this manner of settling our differences he rapidly concluded that the contract I had proposed was acceptable and that ended the discussion.

I have given two instances where the executive committee of the medical staff was helpful to me—one directly and one indirectly. The medical staff can be a great source of help and assistance if it is given the opportunity to participate in these matters. It has been my opinion for many years that the medical profession is not in sympathy with the hospital specialist and the position he has established for himself. It would be to our advantage, therefore, to share our problems in this field with the private practitioners on our staffs. In most instances you can expect their decisions to be logical and con-


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sistent with good administrative practice.

And finally one word about the relationships with anesthesiologists. It is my belief that anesthesiologists should be considered in a different manner than pathologists, roentgenologists, and perhaps even physiatrists. These latter hospital specialists operate departments that employ varying numbers of personnel, whereas the anesthesiologist has only his own personal service to sell and for this reason he is correct in emphasizing his fee-for-service position.

Where nurse anesthetists are employed to supplement his services, it is my opinion that their salaries should be paid by the hospital. Some anesthesiologists have inclinations to develop departments wherein they utilize the services of nurse anesthetists in their employ. This I can see no justification for whatsoever. One further reason for encouraging anesthetists to conduct their business on a fee-for-service basis stems from the substantial fee that they frequently charge for their services. These fees should stand on their own as professional charges and have no place in the patient's hospital bill.

Karl S. Klicka, M.D.
Executive Director
Hospital Planning Council for
Metropolitan Chicago, Inc.
Chicago

An Orderly's Philosophy

Sirs:

One of the jobs at which a hospital's management works constantly is to help all persons working in the hospital to develop and maintain a healthy perspective toward their work, the patients, and the hospital. This, of course, can be accomplished only when each supervisor is transmitting a sound philosophy to the group he or she supervises. Obviously, greater success will be achieved in some areas than in others, depending upon the personal approach of the various supervisors.

Recently an orderly submitted a short statement on one facet of the subject for printing in the nursing service bulletin. He expressed his personal philosophy extremely well, I thought, and it occurred to me that this material might be of interest to readers of The Modern Hospital.

Certainly if all hospital workers had thought through the various aspects of their work as well as this orderly has thought through this particular aspect of his work, patient care would receive a tremendous boost.

James W. Knight
Assistant Administrator
San Jose Hospital
San Jose, Calif.

Editor's Note: *The orderly's statement, referred to in Mr. Knight's letter, follows:*

There is an age-old custom that people working together in an organization follow – that is, to gripe. But to an organization such as a hospital, this custom can very easily become the downfall of successful patient care.

The association of our fellow employes in this capacity, making known our complaints, will probably never change. But griping to a fellow employe is one thing and griping to our patients is another. The latter establishes a feeling of lack of confidence on the part of the patient.

The one idea that seems to be most prevalent in our daily endeavors here at San Jose Hospital is lack of sufficient time to perform our various

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duties. If this attitude is transmitted to the patient, he may soon feel that he has been placed in a "do-it-yourself institution." A patient goes to a doctor because he has confidence in that doctor. A doctor places his patient in our care because he has confidence in us as a smoothly functioning body to carry out the necessary procedures to ensure the recovery or comfort of his patient.

The patient will soon form opinions of us as a group; either that of knowing he is receiving the best care possible, or that of feeling he is not. This feeling in turn is transmitted to the doctors. I feel I am safe in saying the standard answer to many questions asked us is, "I was quite busy"; "I didn't have time"; or "We were so rushed."

All of this adds up to one thing. We are indirectly hurting ourselves! All of us like to say with pride, "We work for San Jose Hospital." But we cannot be proud of our employment if the doctors and the public do not hold us in high esteem. We should remember that as a group working together, we are responsible for the impression held by both these groups.

I propose this solution to our griping problem. If you have to gripe, gripe in private. But for real satisfaction, follow the advice of the pamphlet, "These Doors Are Open." Go to your head nurse or immediate supervisor. If you are still unhappy, go to your supervisor. Then if all these courses seem to have failed in giving you the answer, Mr. Knight's door is always open. Remember that these people are all our fellow employes, and are much better equipped to understand our problems and cope with them than a patient or a doctor. In the interest of professional endeavors, let's not burden doctors and patients with our griping.

Submitted by Truman Robison
P.M. Orderly

San Jose Hospital
San Jose, Calif.

Learn From Others' Errors

Sirs:

I applaud your splendid coverage of the aged with regard to long-term housing and care facilities in the March issue. As the news about "exploding" statistics in aging keeps rolling off the presses, there seems to be some correspondence in efforts to provide for their needs.

The fact that frequently such solutions are not much different from methods considered usual for other segments in our population is beside the point. However it must be indicated somewhere that for the older folks this must be accomplished at the highest standard for the cheapest cost.

It is inspirational to see what our European neighbors have achieved in their desire to make their elders comfortable. Though theirs is not as lush an economic picture as ours, this activity has been stretched over a period of time; thus the gap has been lessened. Europe is a continent composed of small countries with relatively similar problems. . . .

By contrast the varieties of treatment in this country reflect the diversity in peoples, location, religious and cultural bases, plus many other factors that have a pronounced bearing on the institutional image.

On page 140, under a title suggesting a comfortably designed dining room at the Sunset Home in Oregon, the picture shows tables for six. I would have hoped the desire to build for comfort would have considered the aged more. Of course it is obvious that 125 people had to be crowded into a small room. While the table sizes are generous that does not mean it is comfortable to get in and get out of the aisles made by the tables as they are butted against the side walls, although it is certain that the center bank of the tables can be negotiated rather easily.

Another ever present issue is the failure to provide embrasures for wheel chairs and walkers. However these may be somewhere outside this particular view. Wheel chairs are feasible only for diners seated near the entrance to the room. . . . From some of the other material it is easy to gather that economy was essential, but it appears to me that in the dining room setup, the sacrifice to gain seating was too great in cost of patient comfort.

This comment is not intended as criticism of the Sunset Home; it merely indicates the need to be more thoughtful about the needs of people — but this comes from experience, usually improving on someone else's error.

Jacob G. Gold
Executive Director
Orthodox Jewish Home for the Aged
Chicago

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Public Relations

One Way To Get Public Attention Is Through Purposeful Repetition

By Gordon Davis

SOMEWHERE recently I read the report of a primary grade teacher who dented the fender of her new car and cried in vexation: "Oh. Oh. Oh. Look. Look. Look. Darn! Darn! Darn!"


Gordon Davis

For parents who have suffered through the repetitiveness of today's first readers with their children, this tale provokes a laugh because it pokes fun at a ludicrous aspect of an educational practice that is fundamentally serious.

Repetition is essential in education, whether the audience is academic or conglomerate. It is essential because, when you have a serious message to communicate, people seldom listen unless you insist that they listen. This apathy is the butt of innumerable stories beginning with the one about the mule whose master had to club him vigorously to get his attention.

In public education, you can't use a club, but you can use other devices to gain the ear of your audience. One of these devices is repetition, which therefore becomes an inescapable ingredient of any recipe for effective public relations.

In my newspaper days I was frequently frustrated by the fact that Page 1 top head stories invariably were seen by only a fraction of the people most interested in the news they contained. But once printed, the information was dead so far as the paper was concerned. It couldn't be reprinted. It was outdated. There was little opportunity to make certain that a given piece of information really penetrated into the audience for which it was presumably published in the first place.

For this same reason, publicity cannot be considered a dominant function of public relations. It is too transient, too often limited to strictly flash impressions.

In some cases, advertisers seem to have learned the value of repetition all too well. They drive us insane with nonsensical trivialities which nonetheless impress the names of their products on our consciousness.

One of the identifying characteristics of a sound public relations program thus is the extent and skill of its use of repetition. Particularly in the more difficult aspects of hospital public education, essentially the same story must be told to the same audiences over and over again. Some stories, in fact, must be told almost forever.

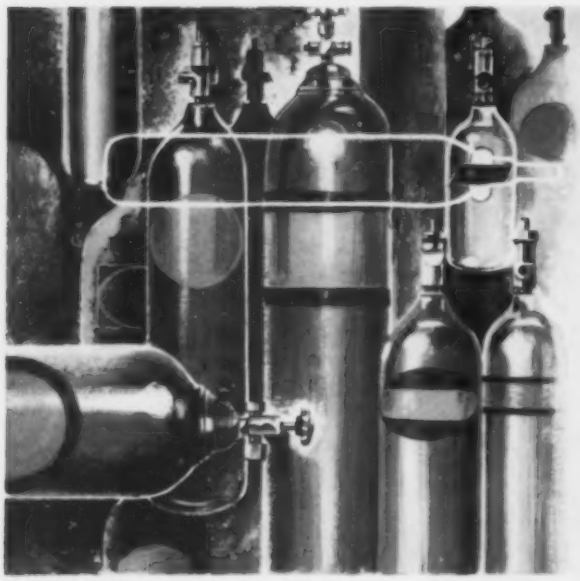
So, for this month's resolution for good public relations, single out some one idea – any idea – that you have been trying to get across to some hospital audience – any audience. Ask yourself whether enough of your auditors have absorbed this idea. If not, maybe they just didn't hear it the first time you expressed it, or the second, or the third.

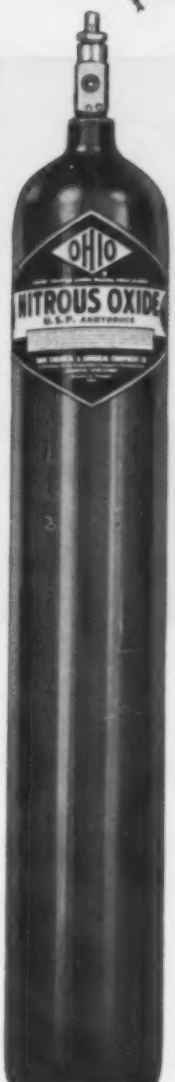
Try saying it again. Try new ways of expressing it. Try to make it oral one time, visual the next, written the third.

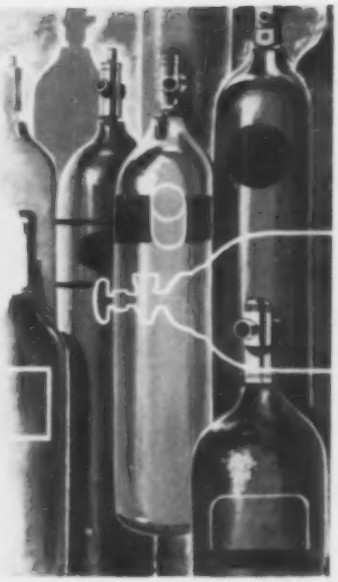
Don't be afraid of becoming tiresome. The best educators – academic as well as public – seldom give a second thought to the possibility that they might seem boring. At any rate, it's better by far to bore people with your message than it is to leave them completely unaware of it. ■

There is a difference

At first glance these two insects appear to be identical. Actually, the bug on the left is the fearsome Indian carpenter bee, while its "twin" is a harmless housefly. This similarity in appearance protects the fly from its natural enemies and permits it to live its life in peace.







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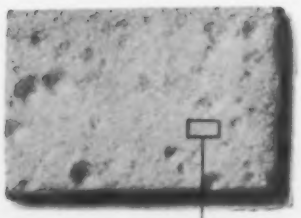

here blood
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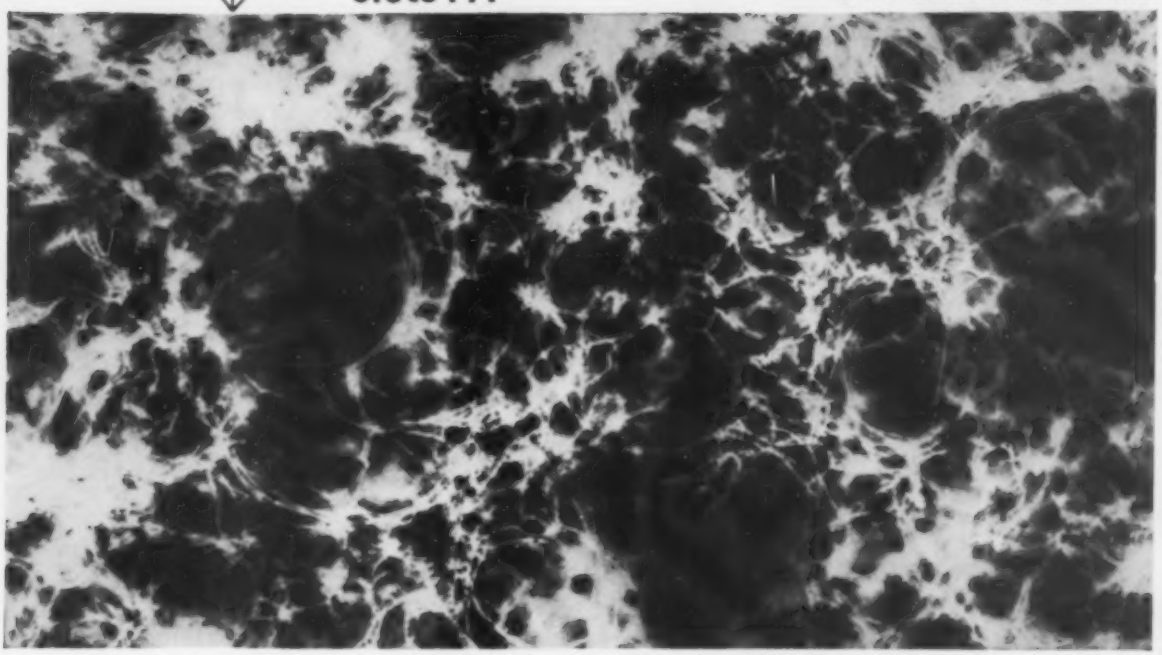

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Just 75 years ago, heating was about as unpredictable as the weather, as temperatures alternated between shivery low and smother-high. Then a Wisconsin schoolteacher named Johnson decided to do something about classroom comfort and thereby launched a new industry!

The Story of the Thermostat

Actually this is the story of a symbol . . . the symbol of an industry that has brought comfort, safety, better health, and efficient working conditions to people all over the world.

. . . In a hospital, surgeons perform a lifesaving operation. Accurate pneumatic controls maintain the temperature and humidity at preselected levels to conserve the patient's strength during surgery.

. . . In a specially equipped manufacturing plant, delicate missile parts and components, with micro-inch tolerances, must be made under temperature and humidity conditions that never vary. At every step in their manufacture, modern pneumatic controls assure error-free regulation of the thermal environment.

. . . Every morning of the school year, millions of students sit down to study and learn in comfortably heated and ventilated or even air-conditioned classrooms. To help provide this ideal environment, the great majority of schools and colleges everywhere depend on precision pneumatic control systems.

. . . Far at sea, one of the nation's deadly new submarines cruises undetected, an elusive, power-laden sentry of the "Silent Service." Her crew lives and works in comfort and safety — in a climate precisely regulated by a pneumatic control system.

. . . Across the continent, pneumatic controls assure safe air conditions in the highly critical processing areas of an atomic energy facility. Pneumatic controllers of extreme sensitivity operate constantly to assure safe disposal of waste air and prevent the escape of contamination.

These are but a few examples of the ways in which modern pneumatic controls play a vital part in regulating the environment in which we live and work — helping to create made-to-order indoor climate for every purpose, controlling temperatures and humidities to a degree undreamed of when Professor Warren S. Johnson invented the first automatic temperature control system back in the 1880's.

Inventor at Work

Though he was probably unaware of the fact at the time, Professor Johnson became the founder of the automatic temperature control industry when he devised a practical way to eliminate the problem of classroom temperatures that seemed to zigzag forever between shiver and swelter.

His first attempt at control — the "annunciator" system — merely called the janitor's attention to overheating, or lack of heat, by ringing a bell in the furnace room. The janitor would then open or close the classroom dampers, as required.

But this land-based version of a ship's telegraph soon gave way to an all-electric method, utilizing a thermostat in each room that would open and close the dampers automatically. And so, the first system of automatic heat regulation was born.

The Electro-Pneumatic System

Intrigued with the possibilities of his long-awaited discoveries, Professor Johnson in 1883 left his post at Whitewater, Wisconsin, State College and came to Milwaukee to devote full time to refining and marketing the Johnson System.

His second major achievement, an electro-pneumatic control system, occurred almost at once. By successfully uniting the forces of *electricity*, for thermostat operation, and *compressed air*, for valve and damper operation, he developed a far more dependable and fully automatic control system. Finally he was ready to go out and revolutionize the comfort standards of the world. In 1885, he incorporated the business which today bears his name.

With branches established in Chicago, St. Louis, and New York, the Johnson thermostat on the wall soon became a familiar sight in the leading buildings of the day. Schools, prominent residences, and small business buildings were first to enjoy the comforts and economies of automatic control. They were followed closely by colleges, hospitals, public buildings, offices, stores, and industrial plants.

From Mikado to Czar

Acceptance grew, markets widened. The fame of automatic controls traveled fast and far. Before 1890, the city of Berlin, Prussia, had written a report about the efficiency of its Johnson System. Later, the palace of the Mikado in Japan was equipped with Johnson Control. The King of Spain and other European royalty became Johnson customers. A special installation was made in the Kremlin in Moscow!

Single Responsibility

Professor Johnson had the foresight to realize that the key to his success depended upon the *proper application* of his controls. Accordingly, he determined, from the outset, that his company should *never sell devices*, but should sell a *principle of control*. This meant that each system would have to be planned, manufactured, installed, and serviced *by Johnson* to meet the exact needs of the individual building.

Over the years, this policy of complete responsibility by a single specialized organization has insured owner satisfaction and saved untold millions of dollars for Johnson customers.

Carrying out this policy has also resulted in the closest possible working relationship between the Johnson organization and the nation's consulting engineers and architects, in a joint effort to provide ever better control of thermal conditions.

Many Johnson "Firsts"

The history of the thermostat and the Johnson Service Company coincides with the period when other pioneers were busy introducing innovations in heating, cooling, and ventilating methods and in developing full-scale air conditioning. Working closely with the research staffs of these manufacturers, Johnson engineers were able to supply the most effective controls for every new development in basic equipment. This cooperation has continued and flourished to the present.

Over the years, the Johnson Service Company has been the source of a never-ending flow of new ideas, which have included virtually all of the key developments in the field of automatic temperature control!

By far the most important was the all-pneumatic control system, perfected in the 1890's and still the standard everywhere. Others include the all-metal thermostat, the famous *Dual* or day-night thermostat, the heating-cooling thermostat, summer-winter thermostats, the airstream thermostat, master-submaster thermostats, supersensitive gradual-acting thermostats, and powerful piston damper operators.

Another famous development was the Humidostat or humidity regulator. And, of course, the Comfostat, an exclusive Johnson instrument that controls room temperatures in relation to humidity conditions. The popular pneumatic control center, for centralized supervision and control of modern air-conditioning systems, also was first perfected by Johnson.

Uninterrupted Progress

As the concept of controlled environment gathered momentum, so did Johnson. Important "firsts" became routine jobs, as the industry looked to Johnson for the answers to new control problems. From the simple comfort needs of the buildings of the 80's and 90's, to the history-making demands of the first scientifically air-conditioned building, down to the most complex requirements of today's commercial and industrial buildings, Johnson has been the leader in the pneumatic temperature control field.

Today, no matter where you go, you'll find the important buildings are equipped with Johnson Control. From the fabulous Fontainebleau Hotel to the mammoth Merchandise Mart to the famous UN Secretariat Building . . . in schools, in sprawling defense plants, in research laboratories, in vital military installations, in shopping centers, in buildings of *every* size and type and in ships at sea . . . there are temperature and air-conditioning control systems by Johnson.

Johnson's work in the hospital field is especially noteworthy, for during the past 75 years Johnson has helped plan and has installed more hospital control systems than anyone else! In countless hospitals, Johnson Control is on 24-hour duty, helping to save lives, increase efficiency, and cut costs.

Johnson Today ... and Tomorrow

To make certain that each installation performs up to expectations, Johnson backs its engineers with the most complete line of pneumatic temperature, humidity, and pressure control equipment in the industry.

To serve you most efficiently both before and *after* a sale, Johnson maintains the largest and most experienced field organization in the industry, with 107 completely staffed branch offices in the United States and Canada, plus full-time, factory-trained installation and service mechanics in over 200 other cities.

This is by no means the end of the story of the thermostat. For against this unmatched background of innovation, experience, and service, Johnson's never-ending search for new and better controls will inevitably lead to dramatic new ideas in the years ahead. As the day of completely air-conditioned cities approaches and as new and unprecedented demands for precision controls evolve, the forward-thinking Johnson organization will always be ready with the right answers.

The Johnson research and development staff and facilities have been expanded three times in the past four years. And final plans for the next major expansion are already underway! In the future then, as in the past, you can continue to look to Johnson for the world's finest controls!

Johnson Service Company, Milwaukee 1, Wisconsin. In Canada: Johnson Controls Ltd., Toronto 16, Ontario.

JOHNSON CONTROL

PNEUMATIC SYSTEMS

DESIGN • MANUFACTURE • INSTALLATION • SINCE 1885

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brings
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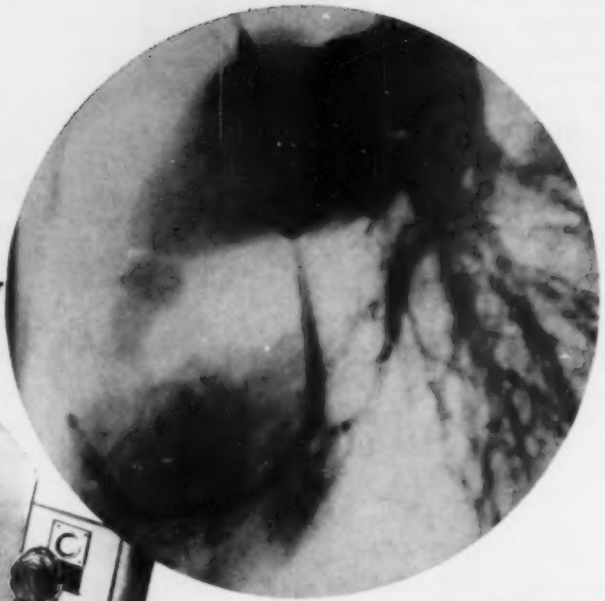
to
cardiac radiology

...and with far less radiation exposure



22 cm diameter fluoroscopic image of Picker image-intensifying tube (shown half-scale here) is big enough to embrace the whole of the adult heart.

The PICKER Cardiological X-ray Unit.

a single comprehensive apparatus with which you can...

fluoroscope directly with a 22 cm image-intensifying tube
(the field is large enough to visualize the whole adult heart)

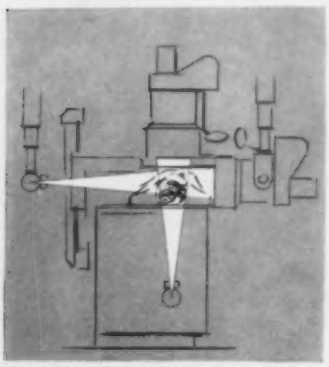
use either a VIDICON or ultra high-gain ORTHICON TV pick-up

monitor continuously on closed-circuit TV
(simultaneously with any number of remote TV screens)

record an examination by cineradiography
(on 16 mm or 35 mm film—at speeds up to 60 frames-per-second)

fluoroscope on a non-amplified 12" x 12" conventional screen
(simply slide the amplifier assembly out of the field)

get a 10" x 12" radiograph anytime during the examination
(simply drop a loaded cassette into the well and expose it)



The Picker Cardiological X-Ray Unit is also available in this biplane model for simultaneous PA and lateral presentation.

Picker X-ray

Much more to this story: get it firsthand from your local Picker man. Call any Picker office (see 'phone book) or write Picker X-Ray Corp., 25 So. Broadway, White Plains, N.Y.

no capital investment if you'd rather rent • **ask about the PICKER RENTAL PLAN**

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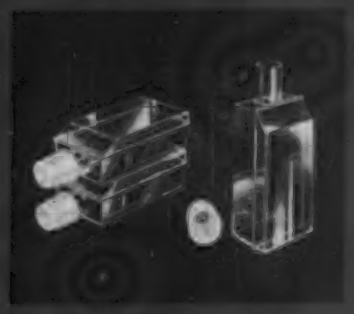
All laboratories are faced with the problem of having suitable containers for the many and varied types of material which must be stored and transported. Containers must be sterile, strong, and economical; some must be unbreakable; some light and cold resistant; some flexible; some impervious to certain chemicals.

FALCON PLASTICS has developed a family of products designed to provide convenient, time-saving receptacles for most of the substances used in laboratory and field procedures. Each FALCON container has a versatility which will suggest many uses in your own specific field of operation.



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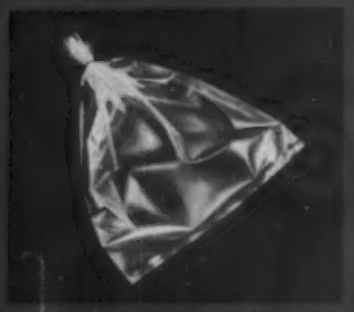

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4½ and 8 OZ. CONTAINERS
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These are molded of tough, translucent high-impact styrene . . . nested for compact storage . . . lids packed separately. The 8 oz. container has a paper cap with internal friction fit. The 4½ oz. size has a polyethylene external snap-fit lid. Both covers prevent spillage and evaporation.

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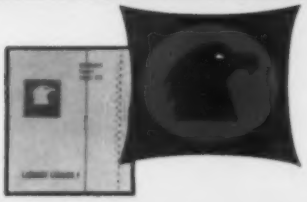
Heavy, 5 mil. polyethylene bag for collection, storage, freezing and transportation of liquids, friable materials, and specimens. 30 mm. opening with screw cap which may be attached to plastic clip on bag to prevent loss . . . cord attached for hanging on hospital bed or elsewhere . . . excellent for industrial use

Send for FALCON Catalog F for information and prices



FALCON PLASTICS COMPANY
5510 West 83rd Street, Los Angeles 45, California
A Division of Becton, Dickinson and Company

How *Imaginative Engineering* Put Taming Chicago's

John Dolio (right) in front of Powers Graph-O-Matic Control Panel with E. S. Anderson, engineer for the Illinois Psychiatric Institute.

The unusual temperature requirements specified for the new Illinois Psychiatric Institute presented an extraordinary challenge for John Dolio & Associates. This Chicago engineering firm was asked to provide an absolutely uniform temperature throughout the 11-story, T-shaped building. Because temperature variations cause extreme discomfort —even pain—to mental patients, the system had to be accurate, foolproof and automatic. Because Chicago temperatures rise or fall to extremes within hours—sometimes minutes —the system had to be capable of sensing the changing weather picture outside and automatically and simultaneously reacting inside.

The resulting design provides all the answers . . . in a Powers pneumatic control system that operates automatically 24 hours a day—every day—at a bare minimum of cost; a system that compensates instantly for sudden outdoor temperature changes; a system that can be checked and controlled by one man.

The result is a functional system of control where practical engineering principles were combined by the Dolio firm with a strong helping of ingenuity in order to whip some of the more unusual problems. For example, since chilled water was to circulate through ceiling heating-cooling panels, a safeguard against condensation was necessary. The engineers solved this problem with a series of dew point controls mounted at various locations in the ceilings. Thus, "controls on a control" prevent water temperature from falling to the point at which condensation could occur.

Phil Derrig, Chief Mechanical Engineer of the Dolio firm, inspects one of the dew point controls specially designed to prevent condensation of cold water in the ceiling heating-cooling panels.

Powers Temperature Control To Work Weather At Illinois Psychiatric Institute

Illinois Psychiatric Institute
Chicago, Ill.

Illinois Supervising Architect:
Louis H. Gerding
Architects:
Shaw, Metz & Associates, Chicago
Associate Architects and Engineers:
Fugard, Burt, Wilkinson and Orth
Consulting Engineers:
John Dolio & Associates, Chicago
Heating, Air Conditioning Contractor:
Gallaher and Speck, Inc., Chicago
Ventilation: Zack Co., Chicago

JOB DETAILS

The system encompasses 12 temperature zones, each designed to operate independently in relation to individual zone exposure problems. Ten zones utilize ceiling heating and cooling panels at which hot and chilled water circulate from zone exchangers. Three-way control valves for the water are modulated by pneumatic thermostats in various rooms. Two zones — auditorium and stairwell — have only heat exchangers (the auditorium is supplied with individual conditioned air).

Master outdoor controls sense the changes in temperature outdoors and instantly reset submaster pneumatic thermostats at the zone exchangers. These indoor-outdoor controls are engineered for foolproof maintenance of uniform zone temperatures.

A central control board, the heart of the Dolio design, monitors the complete heating, cooling and ventilating system. The building engineer alone can instantly check 170 control points by merely referring to the Powers Graph-O-Matic Control Panel.

Temperature controls are inaccessible to patients. All controls in the corridors are wall-mounted and cabinet-enclosed; temperature sensors are mounted in ceiling exhaust ducts.

Easy servicing and low maintenance are two big reasons why a pneumatic system of control was specified by this engineering firm. Efficiency at low cost is characteristic of this type of control — as it is with the Powers pneumatic system installed here.

Safety and comfort for patients is provided for throughout. For example, in hydrotherapy, in showers, in sitz baths, etc., Powers Hydroguard® thermostatic water controls prevent scalding and eliminate dangerous water temperature fluctuations.

Write for the latest Powers Hospital Catalog.
Write us also for catalog on time-saving, money-saving pneumatic tube systems manufactured by our new subsidiary, the Grover Company.

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Di-Crobe is bactericidal under use dilutions. Quick-cleaning action and germicidal power remain stable, even when exposed to heavy soil. Hard or cold water may be used without fear of creating a soap film or of destroying conductivity.

Di-Crobe kills a broad spectrum of microbes, including resistant Staph, at very high dilutions. When not rinsed, Di-Crobe leaves a lasting antibacterial blanket. It is also non-toxic and non-irritating. See our representative, the Man Behind the Huntington Drum, for full details and send for the Di-Crobe Germicidal Cleaner Research Bulletin to get annotated test results.

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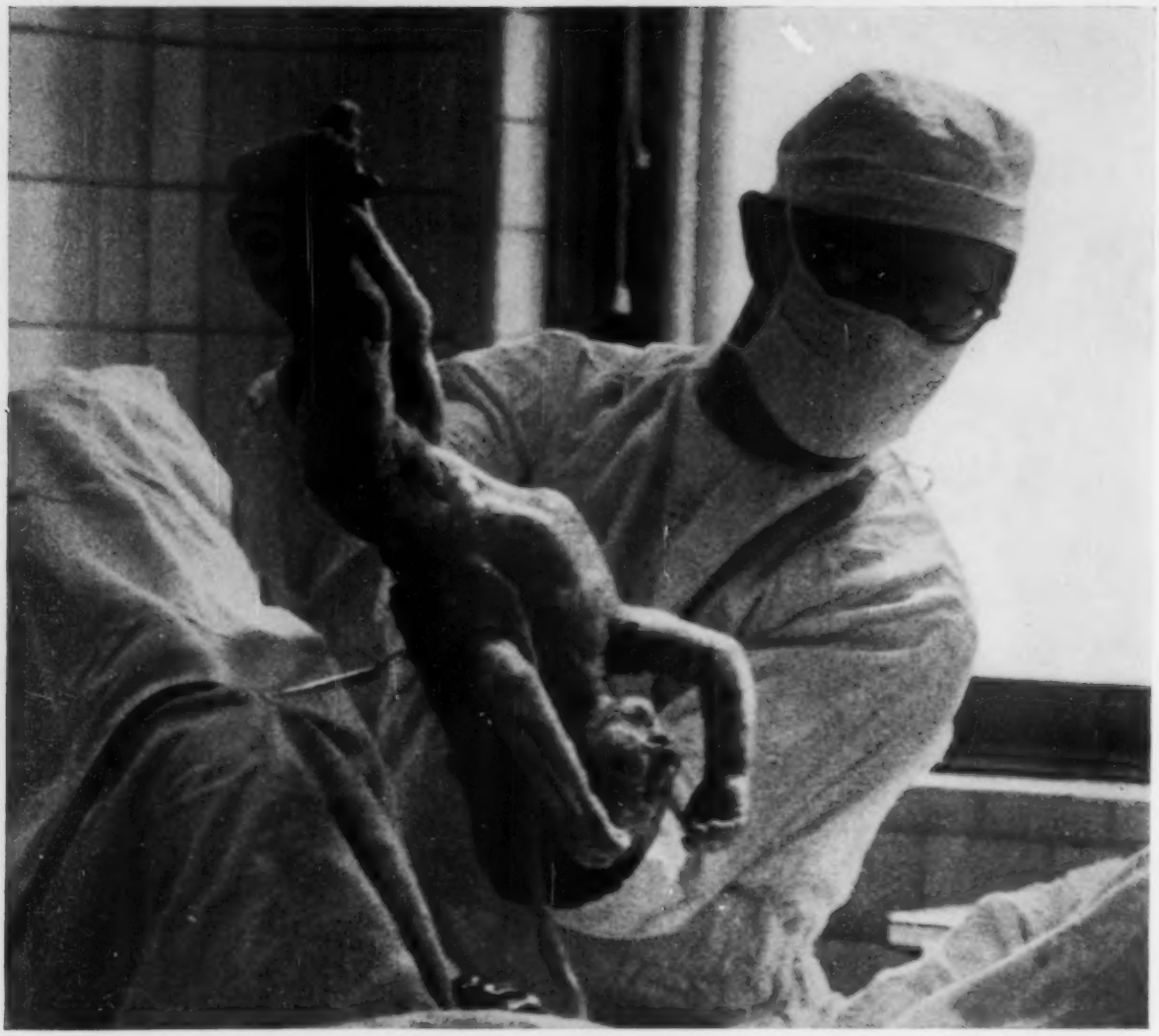
every 7½ seconds another life begins



. . . and 8% are premature

4,350,000* babies will be born in the United States this year—and 8% will be premature. These premature infants should be given every chance for survival. Does your nursery have enough ISOLETTE® incubators?

The ISOLETTE incubator alone provides precise, continuous, fully-automatic control of temperature, humidity and oxygen—vital factors of the premature infant's environment.

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To be ready for the increasing number of premature births—and for optimal protection of even the tiniest infant—make sure your nursery has enough ISOLETTE incubators.

*4,320,000 births were recorded by U.S. Dept. of Comm. in 1959.

The Isolette®

infant incubator by **AIR-SHIELDS, INC.**

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Research and engineering to serve medicine throughout the world

the airkem program...

modern chemistry's answer to environmental sanitation

Enlightened sanitation administrators everywhere are adopting the Airkem program for a healthier* environment. Why?

Because the Airkem program is both comprehensive and effective. It brings to bear 20 years' intensive research on odors and sanitation to help you provide healthier facilities . . . often at substantial savings, or with no increase in present costs . . . yet you get so much more.

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A-3 is but one element in the Airkem program. Another is the use of special counteractants which, introduced through air conditioning systems, control odors and provide an air-freshened effect. We would like to demonstrate to you the benefits of our program. Airkem distributors, located in key centers of the U.S. and Canada, are ready to serve you. Call your local Airkem representative direct, or write John Hulse, Airkem, Inc.

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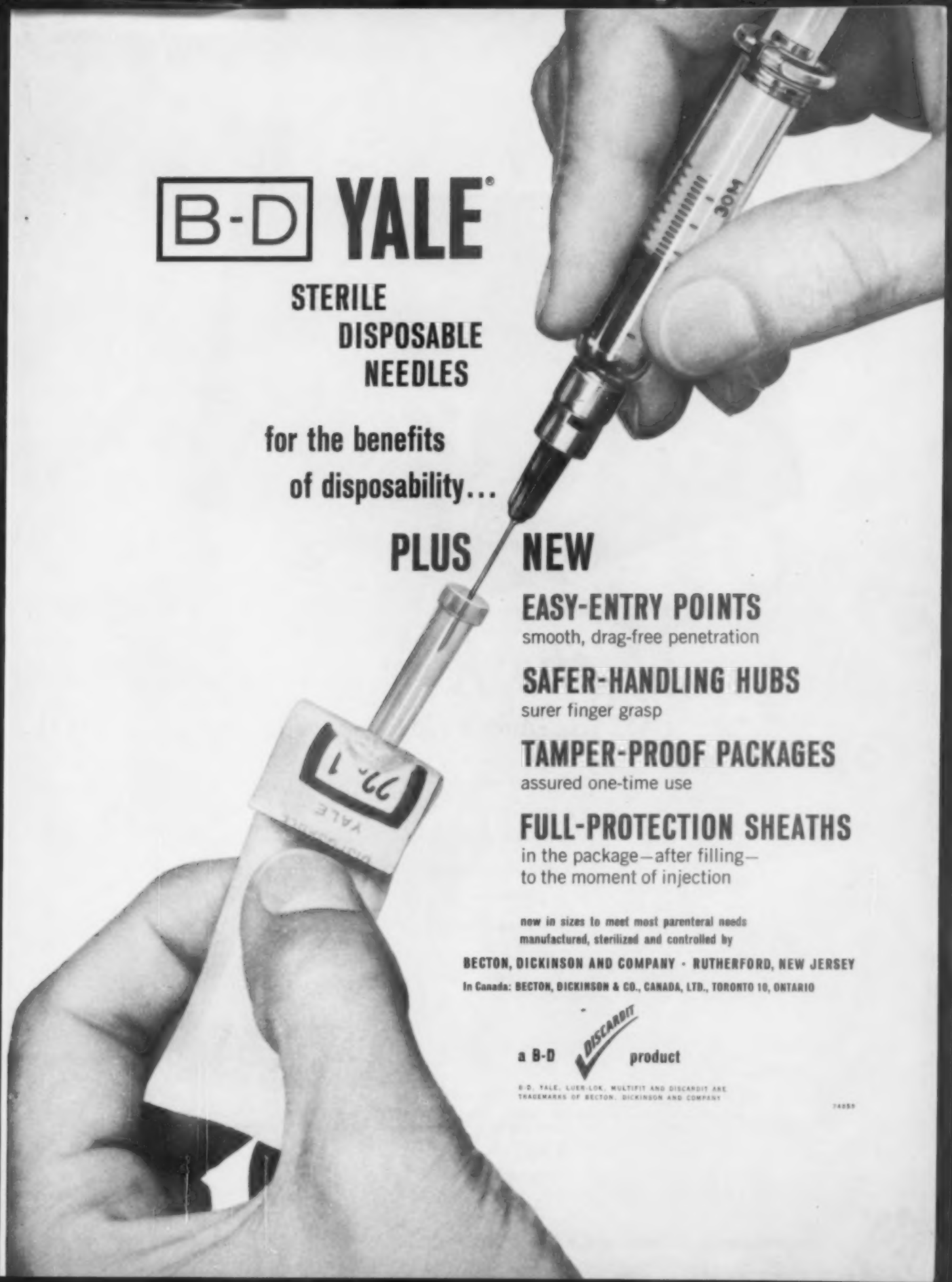

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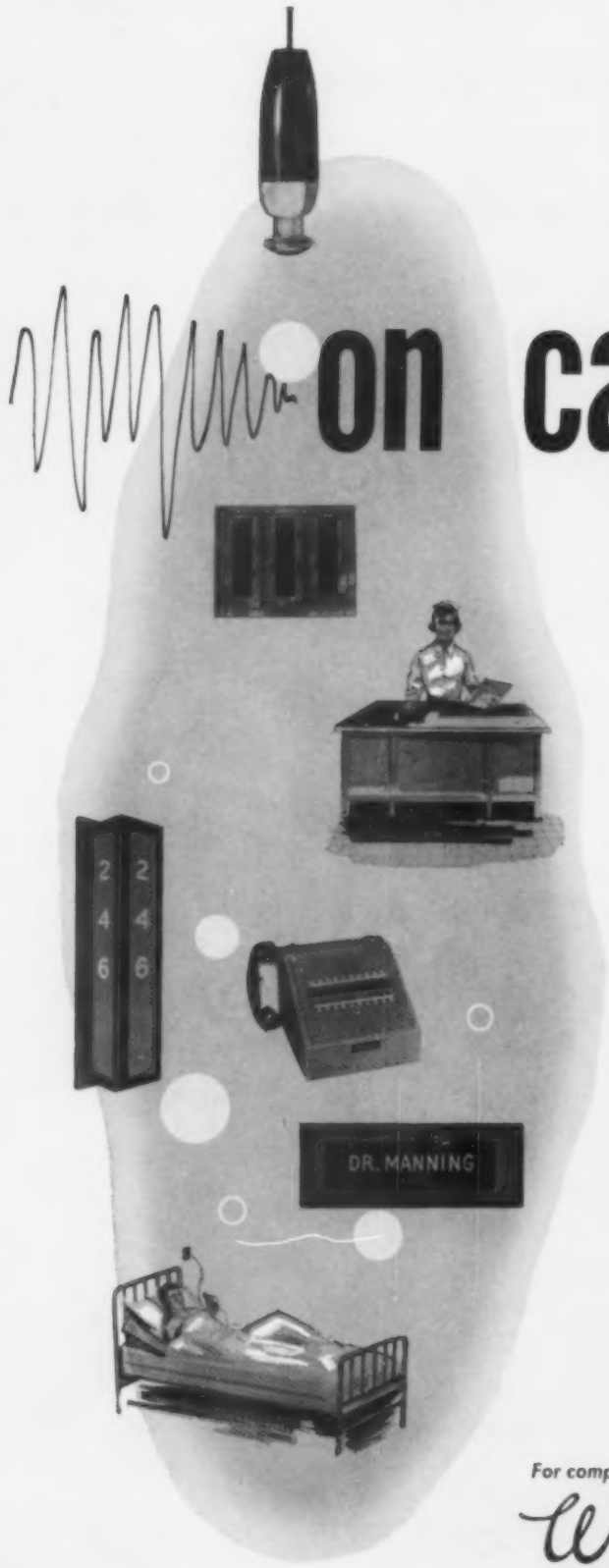

on call

wheelock hospital signals

An achievement in signal system engineering. The Wheelock hospital signal systems are designed to provide simple and dependable communications between patient — nurse and medical staff. The Hospital Signals systems recently acquired by Wheelock Signals, Inc., were originally developed and sold by International Business Machines Corporation.

NURSES CALL SYSTEM provides the patient with immediate 24 hour a day communication with the attending nurse.
A bedside call button when pressed transmits audible and visible signals throughout the Nurses Call System.

NURSES' SUPERVISING AND COMMUNICATING SYSTEM enables a nurse to ascertain a patient's needs before visiting the room and to check patients to determine whether they are breathing normally and sleeping restfully. During the night the nurse can check constantly on any patient without leaving her desk.

DOCTORS' PAGING SYSTEM provides for contacting doctors and other members of the staff while they are in the building.
Essential for the efficient operation of any hospital, the Paging System is designed to meet the visual paging requirements of any size hospital.

DOCTORS' STAFF REGISTERING SYSTEMS indicate at a glance whether a doctor or member of the staff is in or out of the hospital.
To provide this vital service for hospitals of every size, Wheelock engineers can provide simple, flexible, efficient systems.

For complete information on hospital signal systems write to:

Wheelock SIGNALS INC.

LONG BRANCH, N. J.

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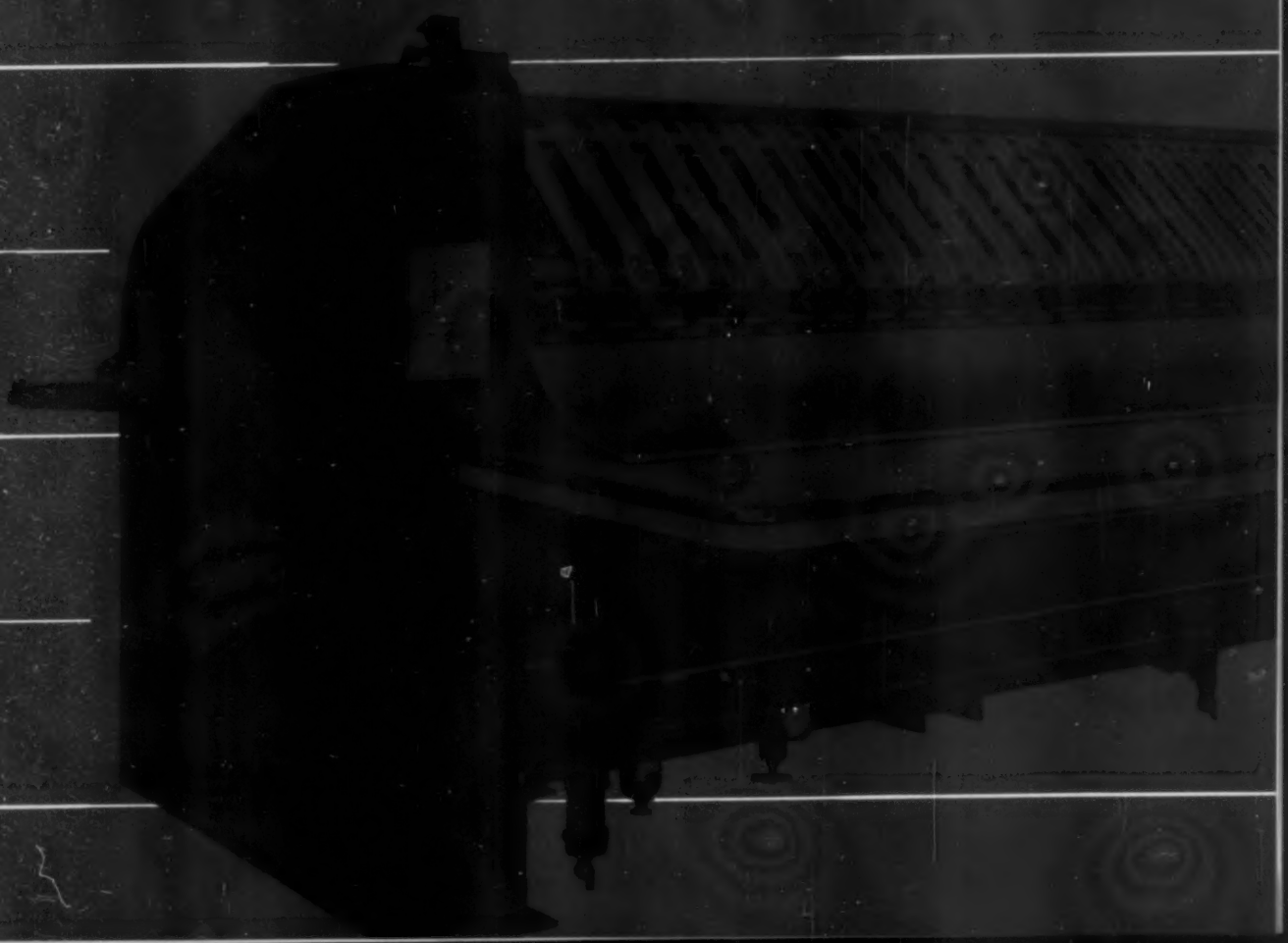
American's **9** *different type Trumatics offer unusual*



It's just a

Never before such a wide selection! Imagine, one, two, three, even four and five folding lanes working independently, in various combinations, or all together as a single full width lane. That means every type and size flatwork piece can be folded automatically at highest ironing speeds.

Cash in now on the benefits of a high speed, labor-saving Trumatic Folder. There's one for your specific need. Check these 9 types, then check with your nearby American representative or write today for free illustrated catalog.

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1 2 3 4 5 6 7 8 9

Type 1-L. A single-lane Folder for large pieces. Used with any 110″ or 120″ Ironer.

Type 2EF-LM. A 2-lane or single-lane Folder for both large and small pieces. The flip of a switch will change it from two to one or one to two-lane operation. Use it with any 110″ or 120″ Ironer.

Type 2EF-LS. Control *automatically* changes Folder back and forth for two-lane or single-lane operation as different size pieces pass through. Folds large and small pieces directly from any 110″ or 120″ Ironer.

Type 2EF-FS. A 2-lane or single-lane Folder especially designed for family service flatwork. A "pick-up" conveyor delivers pieces too small for mechanical folding to a Receiving Tray beneath the Delivery Table. Change back and forth for one or two-lane operation is automatic.

Type 3EF-BA. Automatically folds bib aprons in three 40″-wide lanes directly from any 120″ Ironer. A manual selector instantly combines the three lanes into a single 120″-wide lane for folding large pieces.

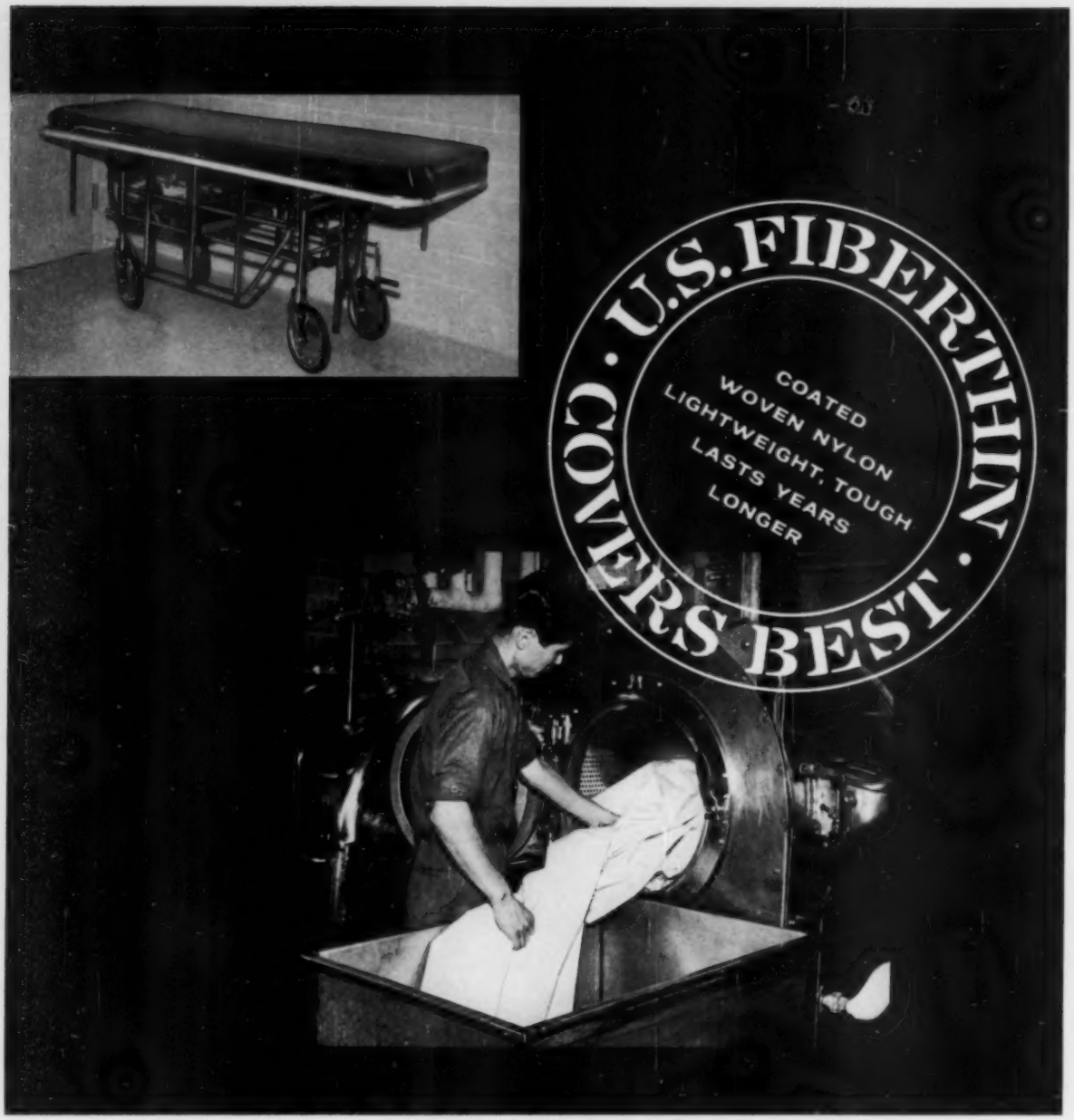
Type 4EF. Four lanes, two lanes or one lane as you need them. The four 30″-wide lanes operate independently, boost production by eliminating stagger-feeding. A manual control also sets Folder for operation of two 60″-wide lanes or one 120″-wide lane.

Type 4UF-BA. Four, three, two, or single-lane folding with the flip of a switch! Ideal for part-time folding of bib aprons. Manual control sets Folder for 4 lanes (two 40″ and two 20″-wide), 3 lanes (each 40″-wide), 2 lanes (each 60″-wide) or 1 lane (120″-wide).

Type 5EF. Five, three, two or one-lane operation gives unusual flexibility to handle a wide variety of flatwork on a single Folder. Simple control changes from 5-lane (each 24″-wide) to 3-lane (two 48″-wide and one 24″-wide) to 2-lane (one 72″-wide and one 48″-wide) or to 1-lane (120″-wide) as needed.

Type 5EF-BA. The same five, three, two and one-lane flexibility as the Type 5EF, plus special features for plants using a 120″ Ironer part time for bib aprons.

Ask your American representative to arrange for you to see our new motion picture on the TRUMATIC FOLDER.



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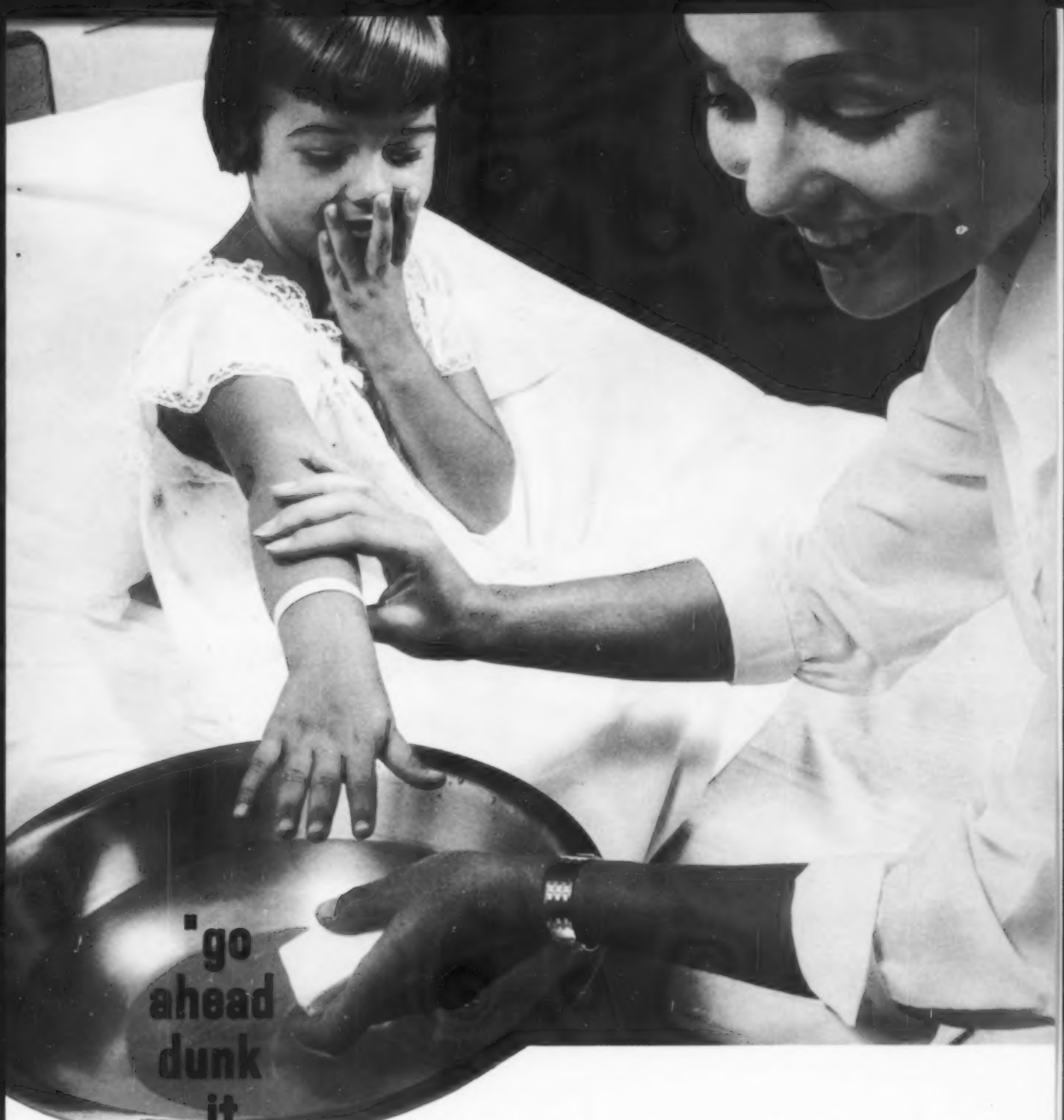
US RUBBER **United States Rubber**



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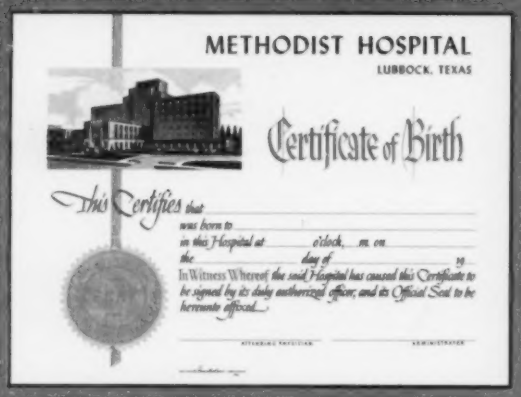

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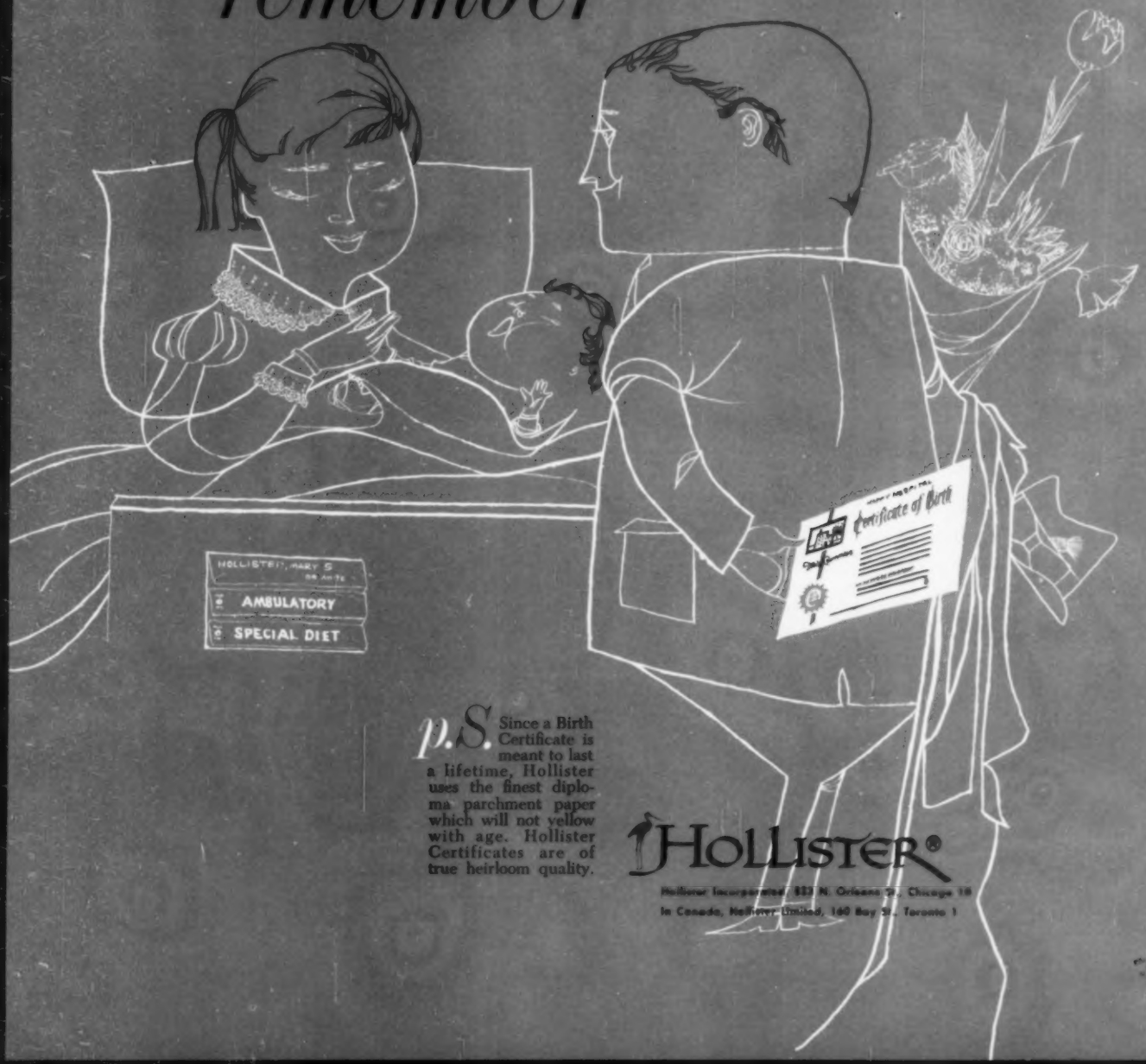

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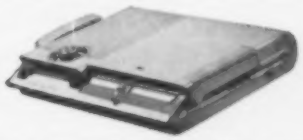

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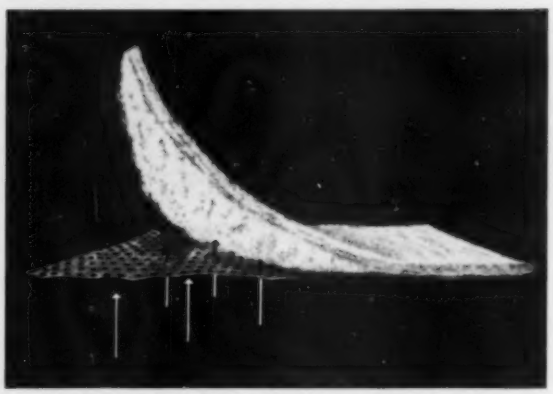
With this dryness and the highly retentive pad, dressing changes are fewer. And you often need fewer dressings per wound—because one Telfa dressing can do what sometimes requires a stack of sponges. Consider this in terms of dollars and hours, and you'll find a noticeable economy. One that can reduce dressing costs as much as 40%. To see how Telfa non-adherent strips are kinder than ever to sensitive tissue, as well as closely controlled hospital budgets, see your Curity® representative.

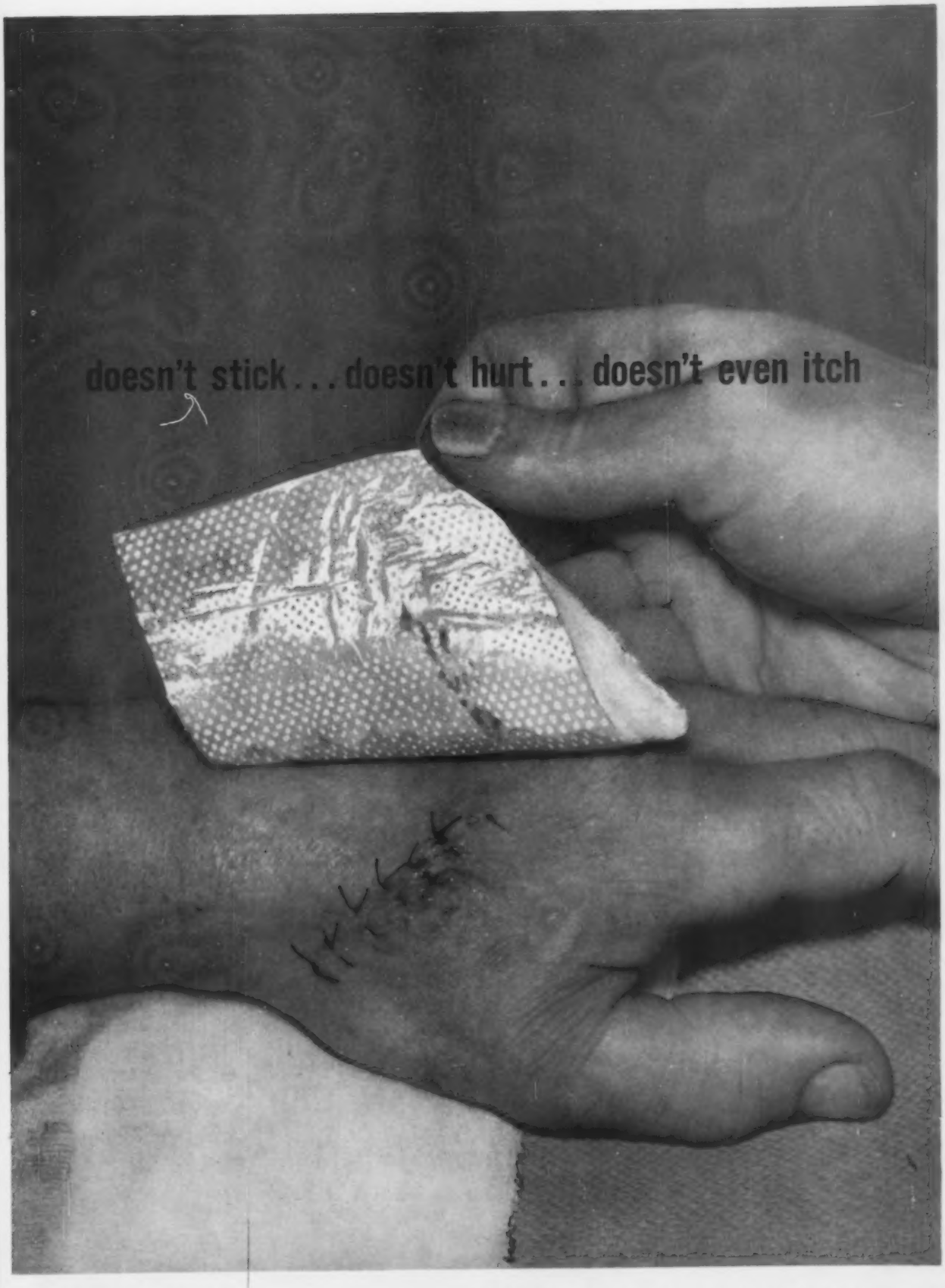
Telfa strips are available in a variety of sizes reaching from 8" x 10" down to 1½" x 2".



The Telfa principle of non-adherent dressings. The highly absorbent pad pulls drainage through the improved, large-bore perforations. The plastic cover, which is bonded to the pad, keeps dressing fibers out of the wound.

Curity®
TELFA®
NON-ADHERENT DRESSINGS

THE KENDALL COMPANY
BAUER & BLACK
DIVISION



For additional information, use postcard facing back cover.

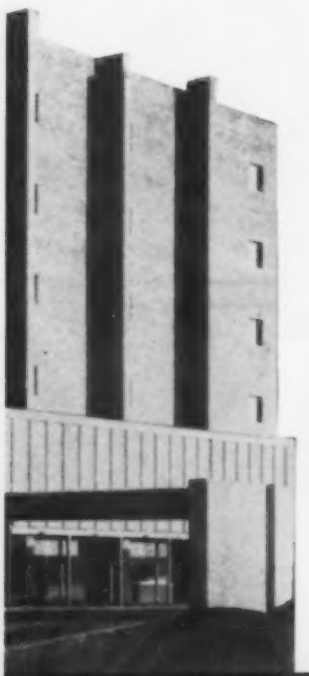
Four

Baptist Memorial Hospital, Oklahoma City. Architects & Engineers: Coston-Frankfurt-Short; General Contractor: G. E. Bass & Company.

PHARMACY

types of air filters provide clean air for this hospital

and they all bear the same brand: AAF



NO SINGLE type of air filter can economically do the complete cleaning job in the modern hospital.

At Baptist Memorial, the clean-air needs of the surgery rooms and cafeteria demanded the efficiency of an electrostatic filter. Another type of filter met the needs of general ventilation, including the gift and barber shops, offices and pharmacy. Still another type whipped the grease vapor problem of the kitchen. The fourth type of AAF filter was installed in the laundry to deal with the special problem of lint.

Unless you consider *all kinds* of air filters for any given installation, you can't be sure of getting optimum correlation of filter performance, filter cost and filter maintenance. AAF is the one-and-only company that *makes* all kinds.

For more information, call your local AAF representative or write direct for Bulletin 510B. Address: Mr. Robert Moore, American Air Filter Company, Inc., 486 Central Avenue, Louisville, Kentucky.

AAF American Air Filter

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KITCHEN

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New ideas, new products for the nursery...

through one service expert!

American representatives understand the needs of the nursery. They offer valuable experience and expert counsel in every hospital area . . . and the widest, most complete selection of products and services in the field. You can rely on American's reputation for quality and for prompt, dependable delivery. Your man from American is dedicated to your hospital's best interests . . . call him with confidence.

Meet Charlie Fellers, a representative in the Atlanta Region. A graduate of Clemson—and the Infantry—he joined our staff in 1947. Typical of American representatives, Charlie Fellers is deeply imbued with a spirit of responsibility to your needs.

The First Name in Hospital Supplies

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Hospital Supply Corporation

Kansas City • Los Angeles • Miami • Minneapolis • New York • San Francisco • Washington

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For the economies of quality– choose Crane

and save on operation, maintenance, replacement

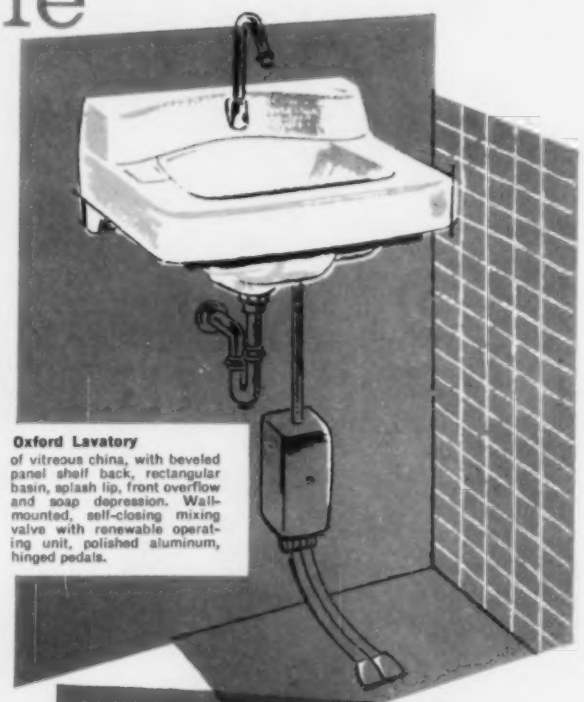
There are two ways to figure plumbing costs in new hospitals. There's first cost. Then there's the cost of owning.

Crane offers savings both ways. Crane plumbing costs no more than comparable plumbing. You get superlative quality. You also get basic engineering and manufacturing features that save you money for years to come.

Crane vitreous china plumbing is made the only way fine pottery can be—with skilled handcraft methods. It's resistant to abrasion and to dulling. Then there's Crane Duraclay—a finish that stands up to hard hospital use and constant cleaning without losing its gleam. It's highly resistant to thermal shock, too.

For operating economy, Crane's unique Dial-ese Control misers water. Dial-ese works *with* water pressure—not against it. It lasts longer than traditional faucets and needs infrequent care.

Your Crane distributor will gladly discuss your hospital's plumbing with you. He'll show you the most extensive line of hospital plumbing made. He'll show you what we mean by the economy of quality, too, and how Crane gives you the edge.



Oxford Lavatory
of vitreous china, with beveled panel shelf back, rectangular basin, splash lip, front overflow and soap depression. Wall-mounted, self-closing mixing valve with renewable operating unit, polished aluminum, hinged pedals.

Whirlton Water Closet
Vitreous china bowl with siphon jet, elongated rim, whirlpool quiet action. 1½" top spud bowl with integral bedpan lugs. Shown with bed pan cleanser with wall-mounted, self-closing, double-hinged pedal mixing valve. (Bedpan not included.)

Surgeons' Wash-up Sink
Duraclay, earthenware vitreous glazed surgeons' wash-up sink with 8"-high back. Knee-action mixing valve with renewable operating units and stirrup handle and goose-neck spout with spray head.

CRANE®

for the economies of quality—at no extra cost

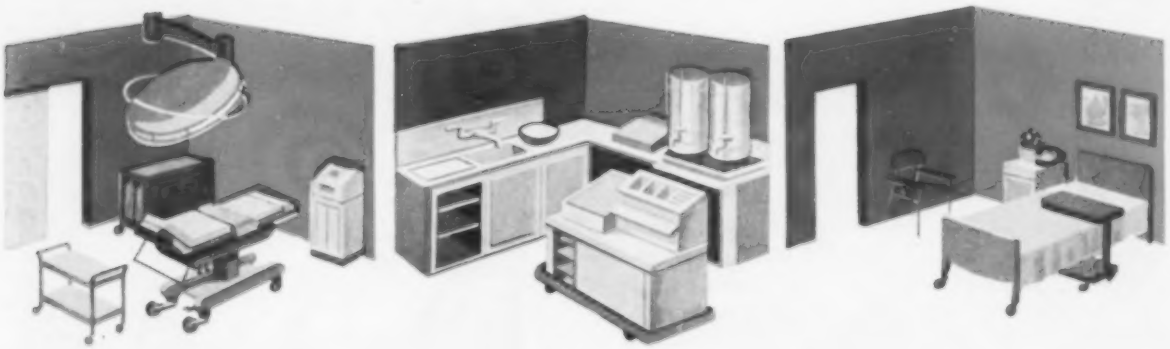
PLUMBING-HEATING-AIR CONDITIONING GROUP • P. O. BOX 780, JOHNSTOWN, PA.

VALVES • ELECTRONIC CONTROLS • PIPING • PLUMBING • HEATING • AIR CONDITIONING

Permanently

GERM-PROOFED

vinyl wall covering



Modern-Cote "33c"

● Bacteria and fungus *can't* grow on Modern-Cote "33c" vinyl wall covering.

Corobex® impregnation permanently guarantees it. Laboratory tests prove it.*

And Modern-Cote presents such a tough surface . . . an "armor" of clear vinyl . . . that it needs no maintenance beyond an occasional washing.

Any color or pattern you choose from the unlimited Modern-Cote selection of fabric-backed vinyls will stay bright and new for a lifetime.

Modern-Cote has earned a Class A fire rating (OBC, Section 1203.34) based on a flame spread rating of only 10 in tunnel tests.

*Write for details now . . . laboratory confirmation on Modern-Cote bacteriostatic and fungistatic action . . . a Modern-Cote catalog . . . and the name of your nearest Modern-Cote dealer.

NEW CASTLE PRODUCTS, INC. • *New Castle, Indiana*
Canada: New Castle Products Canada, Ltd., St. Lambert, Que.

Modern-Cote *by* **modernfold**®

from Honeywell . . . ANOTHER DIAMOND JUBILEE PRODUCT

Honeywell's ClockMaster System in your hospital

Master Clock perfectly synchronizes all clocks in the Honeywell ClockMaster System for dependable scheduling of hospital activities.

The Honeywell ClockMaster System makes it easier for your entire hospital to run *on time!* Staff members are always assured of perfectly synchronized time, no matter where they may be in the hospital. This means not only closer coordination of hospital activities, but also that pill-dispensing, examinations, surgery and laboratory work can be kept *on schedule.*

There's never a worry about clocks being out of step, either. Every clock within the system is automatically checked—and corrected if necessary—once *every* hour from a centrally located master clock. Even after a power failure, no matter how localized or momentary, you get individual correction at the *first* accuracy check.

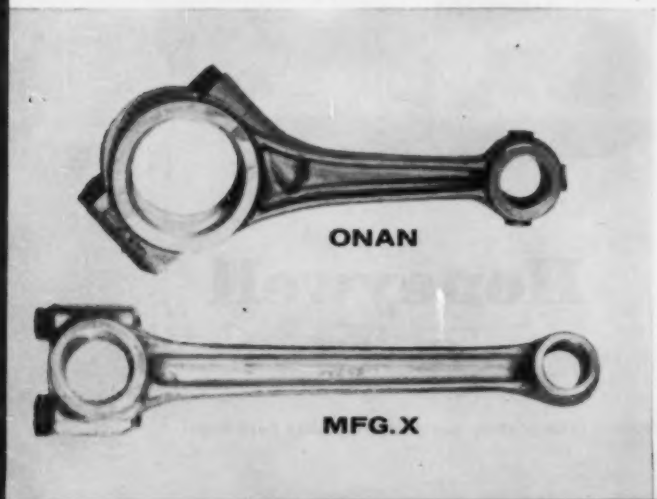
For special effects in certain areas, including patients' rooms, be sure to see Honeywell's wide new line of Decorator Clocks. Select any of 33 attractive new faces as part of your centrally controlled clock system.

In addition to the accuracy and reliability of a Honeywell ClockMaster System, you get dependable nationwide service —the kind of service you'll learn to count on when you buy *any* Honeywell system. For the complete story, call your architect or engineer today, or write: Honeywell, Dept. MH-5-86, Minneapolis 8, Minnesota.

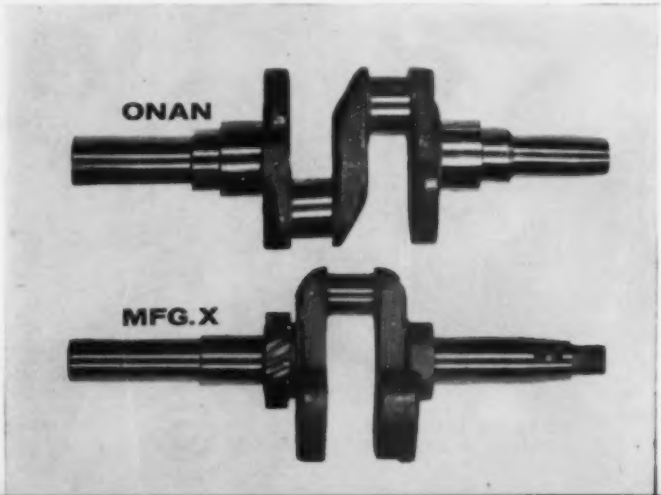
Big, beefy bearings make than ordinary

Look at the brawn in this Onan bearing from a 20 HP engine—more than twice the bearing area of most competitive bearings. Look at the built-down-to-a-price bearing from a 20 HP competitive engine. It's about half the size. Which bearing do you think would last longer?

Connecting rods—The shorter stroke of the Onan engine permits the use of a shorter rod, a more rugged design that stands up longer under heavy duty service—another example how Onan builds *up* to performance, not down to a price.



Crankshafts—Larger diameters of main and rod journals make Onan crankshafts stiffer and stronger, minimizing the possibility of breakage or bending. More "muscle" throughout Onan engines means longer life, extra years of full-rated performance.



Onan last years longer electric plants

Onan bearings are about twice the size of most competitive bearings

Bearings take a beating in any engine. But, with Onan's bigger bearings the strain is spread over a wider area, giving you longer, more economical engine life.

This is just one example of the extra quality you find in Onan Electric Plants. Each one is checked out at full load for hours before it goes to the shipping dock. Engineers have designed 134 separate tests to make sure it operates the way it is supposed to. Not only that, inspectors from independent laboratories pay surprise visits to the Onan factory, pull units off the line and put them through their paces. It's a double check—on Onan tests and testing methods.

There's an Onan representative near you, ready to tell you about the complete line of Onan Plants, from 500 watts to 230,000 watts. Look for his name in the telephone classified section in all major cities, or write direct.

ONLY ONAN GIVES YOU THIS GUARANTEE

Onan®

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For additional information, use postcard facing back cover.

"SCOTCH" BRAND HOSPITAL AUTOCLAVE TAPE NO. 222 seals linen or paper packs quickly, surely. And these unmistakable diagonal markings appear only when this tape has been through your autoclave machine. No chance of these markings being accidentally activated by radiator heat, sunlight or a dry air pocket in a faulty autoclave . . . only correct levels of heat and moisture can make them appear.

Nothing on the outside of a package, of course, can guarantee sterility of the contents.

Simplify hospital routine with

"SCOTCH" BRAND DOUBLE COATED TAPE NO. 665 is sticky on both sides—makes quick work of mounting charts and records invisibly. No awkward liner . . . "SCOTCH" BRAND Double Coated Tape peels off the roll ready for use. Another work-saver is **"SCOTCH" BRAND NO. 800 ACETATE FILM TAPE**—for mounting and protecting records where aging is a problem. Will outlast records themselves.

"SCOTCH" BRAND MAGIC MENDING TAPE NO. 810 is ideal for mending valuable or permanent records. It practically disappears on contact with paper, won't ever cloud or crack or ooze adhesive. And you can write on it with pencil, ink or typewriter. Familiar **"SCOTCH" BRAND CELLOPHANE TAPE** speeds every kind of office job—sealing, holding, mending, protecting.

SCOTCH® BRAND Tapes

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MINNESOTA MINING AND MANUFACTURING COMPANY
. . . WHERE RESEARCH IS THE KEY TO TOMORROW

3M COMPANY

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Why management was *so Concerned* about Paper Napkins

No one knows better than Management that savings come from a careful regard for costs.

That's why they were concerned when they learned that they could save as much as 20% on paper costs by switching to Fort Howard Napkins in the cafeteria and Fort Howard Towels and Tissue in the washrooms. And to this organization, a saving of 20% was important.

Fort Howard quality Paper Towels, Tissue, and Napkins are available in a wide range of grades in all well-accepted rolls, folds, and styles. This means you can cut costs by selecting the proper grade, fold, roll, pack, and price range that you require to meet your needs exactly.

There is a Fort Howard representative nearby anxious to demonstrate to you how dining room and washroom expenses can be cut, and high standards of service maintained.

Fort Howard Paper Company

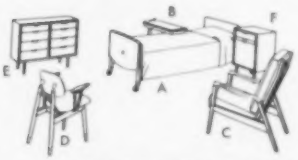
Green Bay, Wisconsin

Sales Offices in New York, Chicago, Los Angeles

America's Most Complete Line of Paper Towels, Tissues and Napkins

CARROM 3000 GROUP

the traditional warmth of walnut in trend-setting design



A – E59-9W-4 Electric Adjustable Height Bed
B – 3-1950 Overbed Table
C – 3-1108S Hi-Back Convalescent Easy Chair
D – 3917S Arm Chair
E – 3055 Double Chest*
F – 3002 Bedside Cabinet*

Also available
- M59-8FW-2 Manual Adjustable Height Bed
- Patient Controlled Electric Spring

The friendly charm of Satin Walnut creates a rich and secure atmosphere . . . in keeping with today's concept of patient care.

Functional simplicity . . . provides easy cleaning plus a trim, uncrowded look in every room.

Carrom 3000 brings you a craftsman's choice of Walnut woods, Walnut finished hardwoods, Mist White Formica and Satin Chrome . . . all blended into rugged, durable units.

Trend-setting! . . . with ideas and innovations you haven't seen before!

WRITE CARROM 3000 PLANNING DIVISION FOR DETAILED INFORMATION

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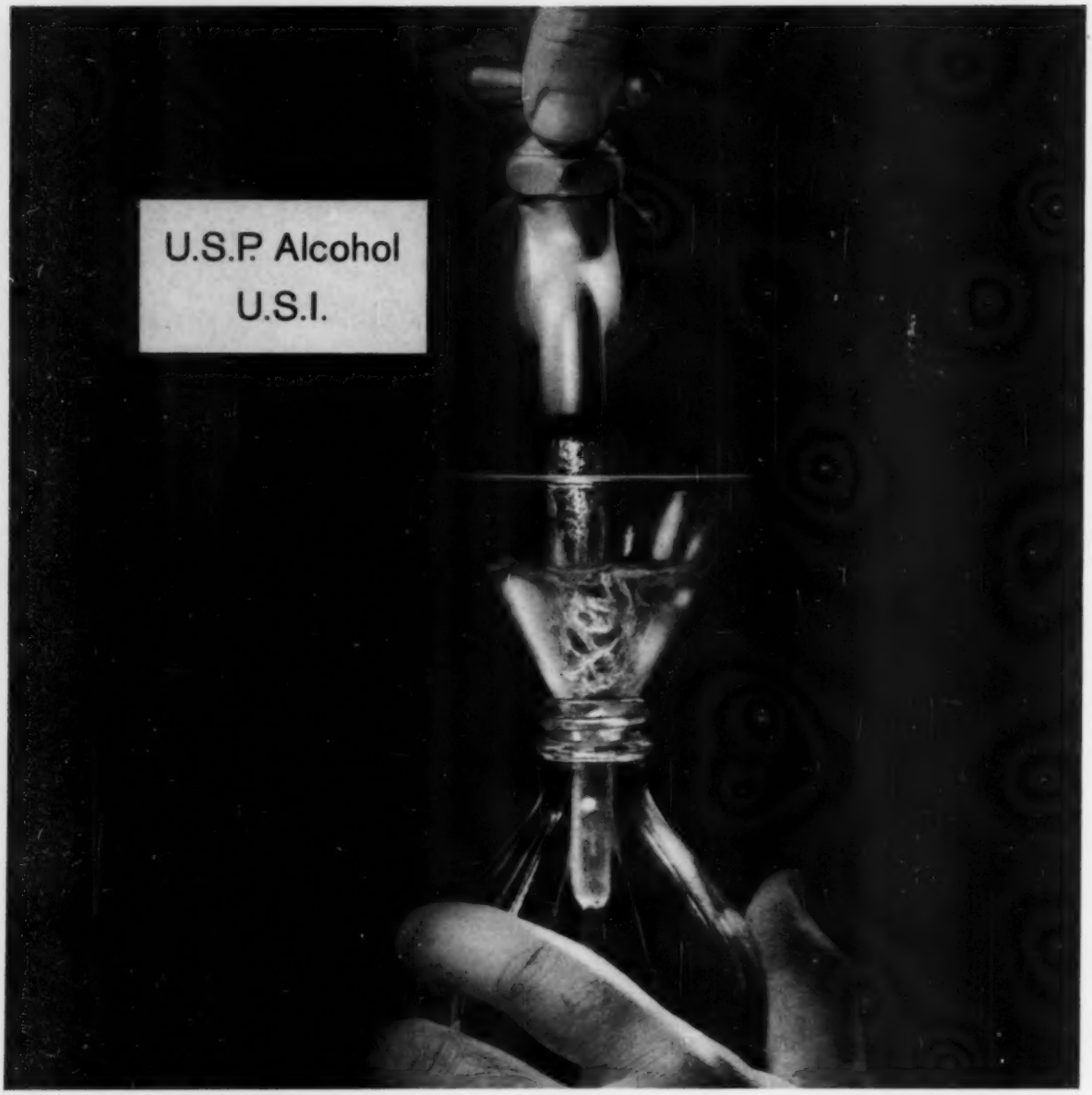
*Designed by G. Luss of Designs for Business, Inc.



It's like having alcohol piped in ...when you buy from U.S.I.

Piping alcohol into hospital pharmacies is not practical. It's not necessary either. U.S.I.'s dependable delivery service keeps one of nine nation-wide bonded warehouses on tap for your hospital . . . assures ready availability of the pure alcohol you require.

Being able to count on U.S.I. alcohol deliveries helps you avoid stocking more than you need. Storage space is freed and inventory problems are reduced.

There are other advantages as well when you buy U.S.I. alcohol. U.S.I. salesmen can help you with any questions involving the use of alcohol – for example, the handling of alcohol permits and records.

U.S.I. is America's oldest producer of hospital and industrial alcohol. For over half a century, we have supplied pure alcohol to hospitals throughout the country. When you buy from U.S.I., you get the benefit of this long experience – and you get service that's as modern and dependable as a pipeline.

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8 second magic in I.V. set-ups with the Cutter Saftisystem "28"™†

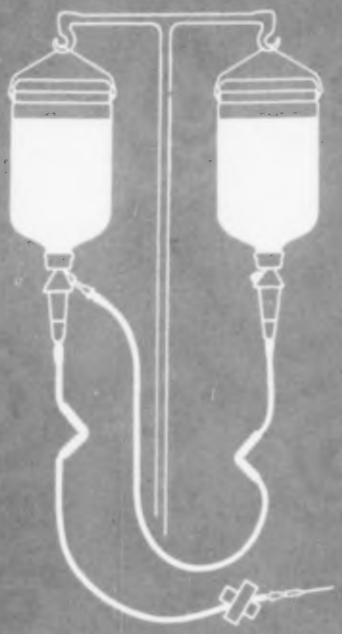
remove metal seal and disc

plug set into center of stopper with a quick thrust

quickly invert bottle to visually check for vacuum and to automatically establish fluid level in drip chamber; clear tubing of air and infuse

†Patent Pending

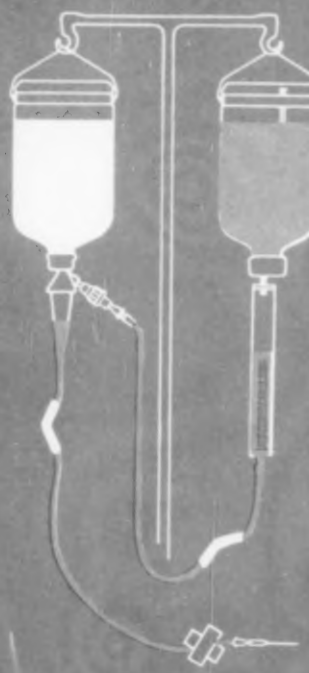
CUTTER



I.V. TANDEM SET-UP with SAFTISET-TANDEM "28"™

"28" tandem hookups are easier save time and temper

Tandem setups become easy as bottles hook up through the air inlets and the flow automatically transfers from one flask to another as containers empty.



BLOOD TANDEM SET-UP with SAFTIFILTER-TANDEM "28"™

THE FIRST MAJOR ADVANCE IN SOLUTION SYSTEMS SINCE DISPOSABLE SETS

The Cutter Saftisystem "28" consists of a 28 mm. Saftiflask® and improved injection sets. A new air inlet with a filter does away with the air tube, permits use of a solid stopper with a single point of entry, and permits only filtered air to enter the flask.

The Saftisystem takes just 8 seconds to set up. There's no searching for the point of entry as there's only one place in the stopper where the set plugs in. The bottle, when inverted, automatically establishes a level in the drip chamber, and the incoming filtered air bubbling up gives a visual check for vacuum.

Medication can be added (aseptically) either before or after the flask has been suspended on the T stand, even after infusion is started.

Hospitals can convert to the Saftisystem "28" without confusion as it is compatible with all closed systems of I.V. administration.

SEND FOR COMPLIMENTARY WALL CHART EXPLAINING THE SAFTISYSTEM "28" IN DETAIL.

CUTTER LABORATORIES
Berkeley, California

POUR-TYPE SAFTIFLASK® "28"™

(with screw cap)

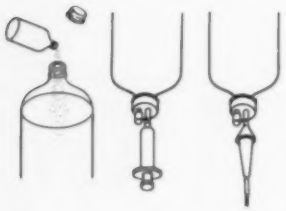
in the operating room

For all rinsing and cleansing procedures wherever a sterile, pyrogen-tested solution is needed.

in the emergency room

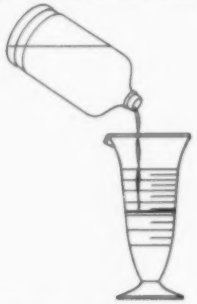
Cleansing and irrigating of wounds.

at the bedside



For regular parenteral administration. Provides easy access for those physicians who wish to pour additives into solution. Contents of flask may be administered with I.V. set connected to the luer outlet of a special polyethylene screw-cap attachment with air-inletting filter. Contents of flask can also be withdrawn with a syringe through luer outlet opening.

anywhere in the hospital



Pour-type bottles may be used as basic solutions in preparing individual electrolyte or other types of solutions.

Solutions available in the *Pour-Type Saftiflask "28"*: Normal Saline, Distilled Water and Dextrose 5% in Water. Supplied in 250 cc., 500 cc. and 1 liter bottles with easy-to-distinguish orange labels.

(Above) NEW WIRELESS REMOTE CONTROL TV

Mobile or "fixed-location" . . . patient completely operates set from anywhere in room . . . no wires . . . no batteries. Other custom built-in type installations available, (wall, ceiling, furniture, etc.) "Nurse-call" feature in Hospix pillow speaker control, can be combined where desired. Hospix master antenna system permits closed-circuit in-hospital telecasting of religious programs, medical and nursing instruction, Hi-Fi music, bulletins, etc.

(Right) MOBILE TV WITH EXCLUSIVE BUILT-IN FEATURES

- Patient-operated at bedside
- Space-saver safety stand
- Swivel-top for best viewing
- Dual pillow speakers
- Metal parts chrome plated
- Retractable power cord reel
- Volume limiter — sound control
- Sanitary — all metal construction

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NOW — YOUR CHOICE OF HOSPIX EQUIPMENT FOR MOBILE OR BUILT-IN "FIXED-LOCATION" REQUIREMENTS

ATTENTION:
Hospix specializes in built-in antenna systems and custom TV equipment for existing and new hospital structures.

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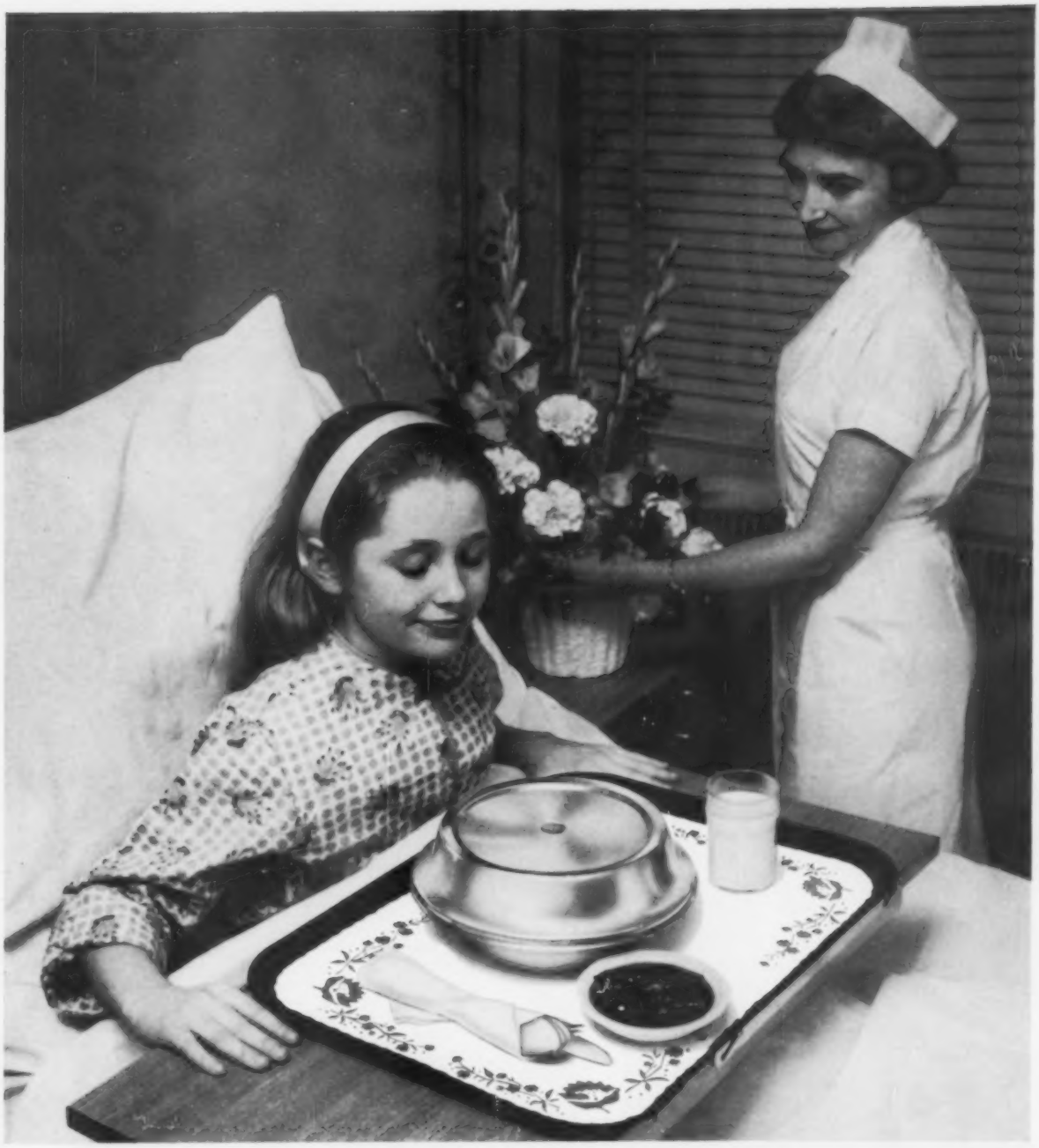
Seven-Up's "SECOND LABEL" should be your FIRST THOUGHT

Purity was never more self-evident. The back of every 7-Up bottle proves it. On this "second label" an ingredients listing proudly tells what 7-Up contains. Nothing more, nothing less.

Water treated to be colorless, odorless, tasteless; then carbonated. *Sugar* that meets standards more rigid than those for table sugar. *Citric acid*, the natural acid present in citrus fruits. *Sodium citrate* to help develop the fresh, clean taste of 7-Up. *Natural oils* pressed from fresh lemon and lime peel, and super-refined to select and concentrate only the most desirable parts of their pure, natural flavors.

Seven-Up is exactly what our "second label" says it is . . . finest quality which you may recommend with confidence.

Nothing does it like Seven-Up!



Snap meals out of the "ho-hum"
serve them on Roylprints* and Roylies*

Watch spirits perk up when you serve food on crisp, colorful ROYLPRINTS and ROYLIES. It's the inexpensive little touch of luxury that lifts each meal out of the ordinary—tells your patients that *you* care. Roylprints and Roylies are sanitary. Save on tray cleaning time too. The cost? About a penny a tray. In stock designs and colors, or special printings. For more information and a free day's supply, write Royal, Dept. H.

**Printed paper place mats, doylies and tray mats*

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Standard Packaging Corporation

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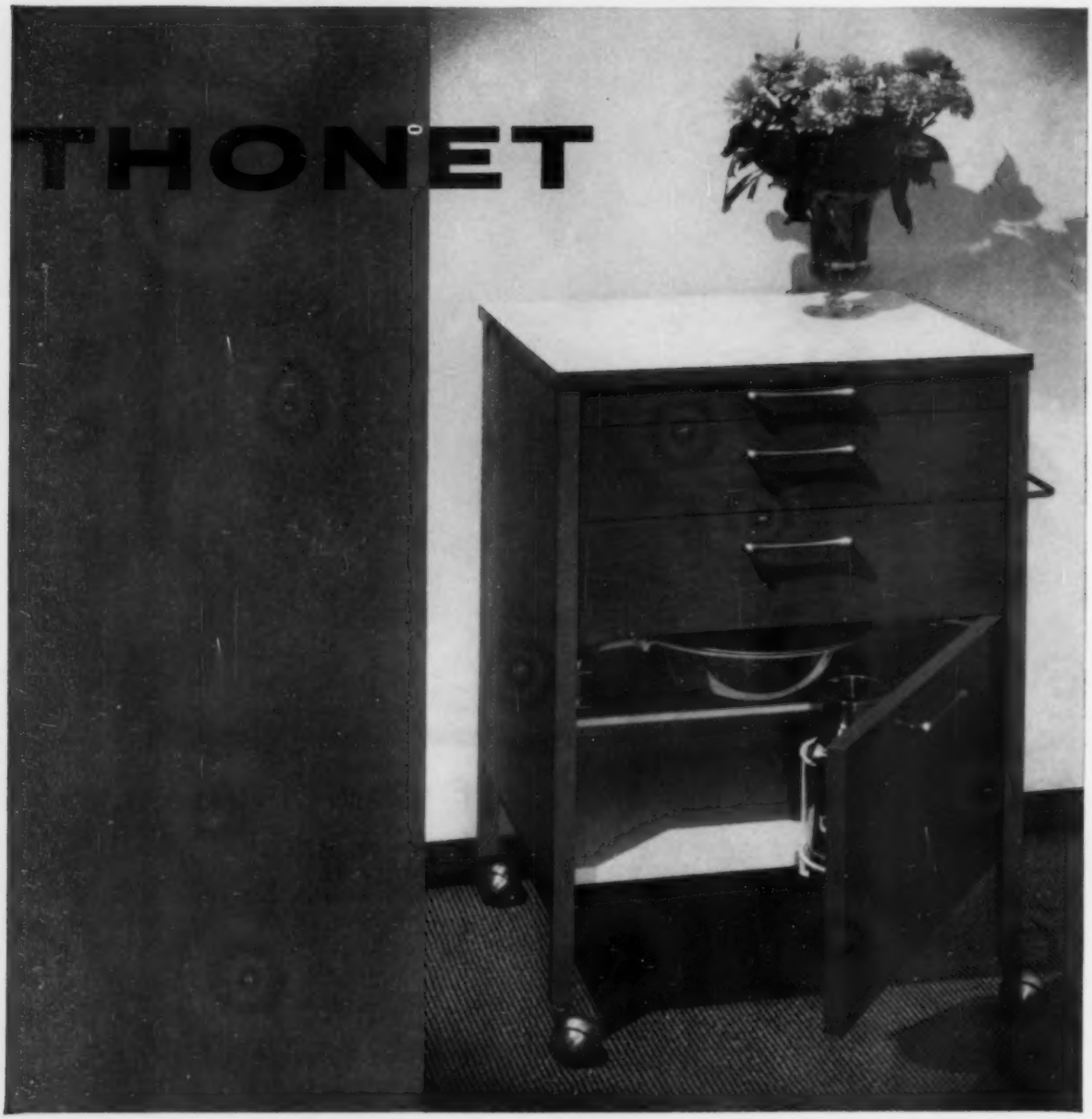
SINCE 1830 MAKERS OF FURNITURE FOR PUBLIC USE

Bedside cabinet 180-102. Also other furniture for hospital rooms, public areas and nurses' quarters.



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KILLS STAPH

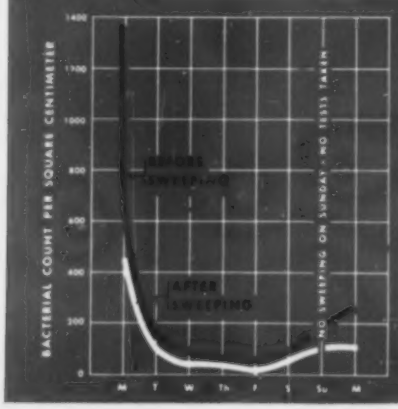
NEW HOSPITAL Velva-Sheen MOP TREATMENT

fights cross-infection by killing staphyloccocus aureus where it dwells.

PROTECT PATIENTS by eliminating bacteria-laden dust!

HOSPITAL Velva-Sheen MOP TREATMENT, with bactericide

- Is non-toxic, residual and non-selective
- Preserves effectiveness of conductive floors
- Is classified SAFE as to fire and slip hazard by Underwriters' Laboratories
- Beautifies and protects all hard surface floors



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has been laboratory tested and hospital proven, and is now in use by many hospitals throughout the country.

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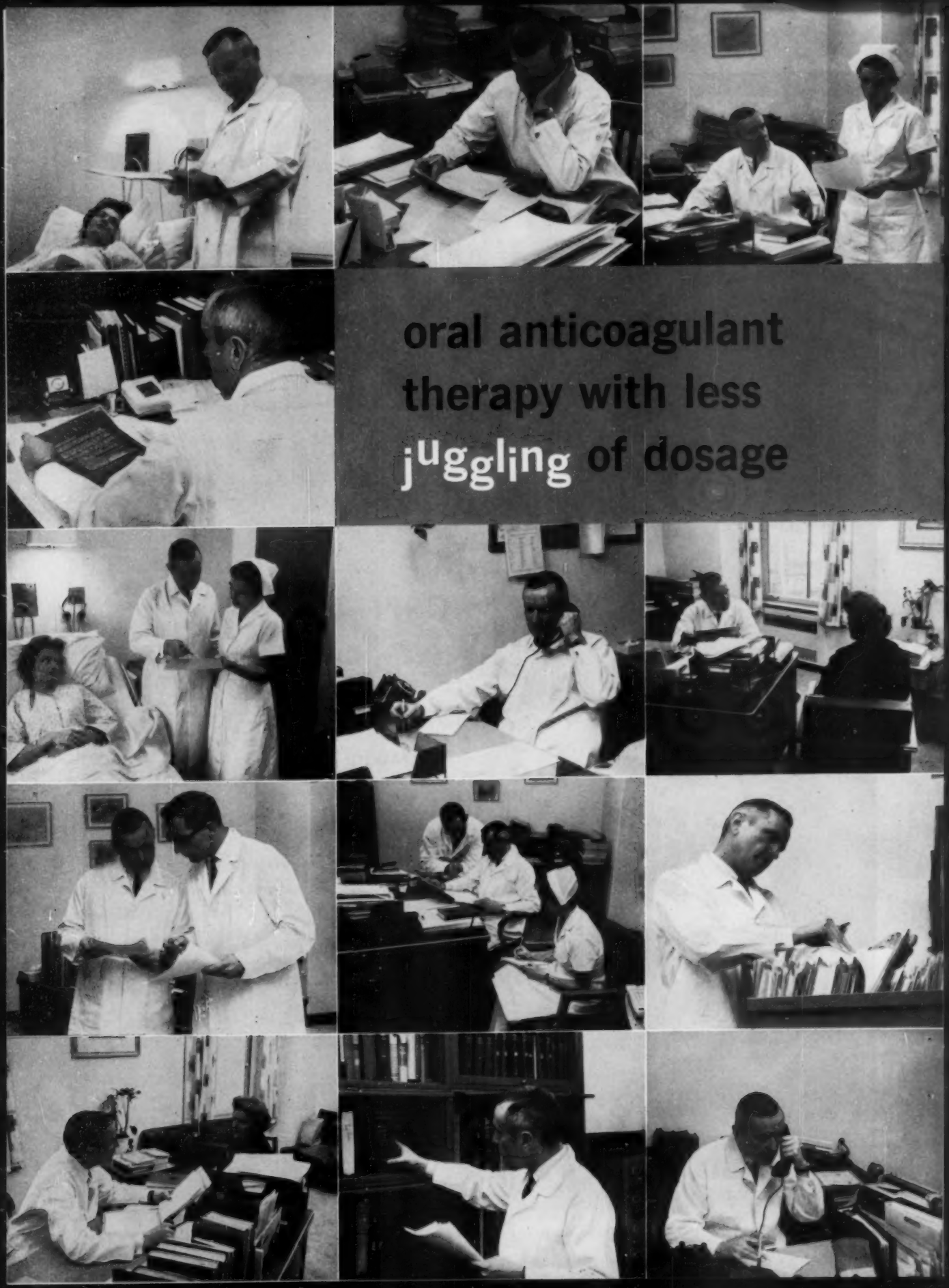

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(Warfarin Sodium, Abbott)

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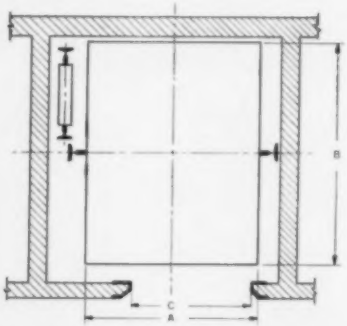

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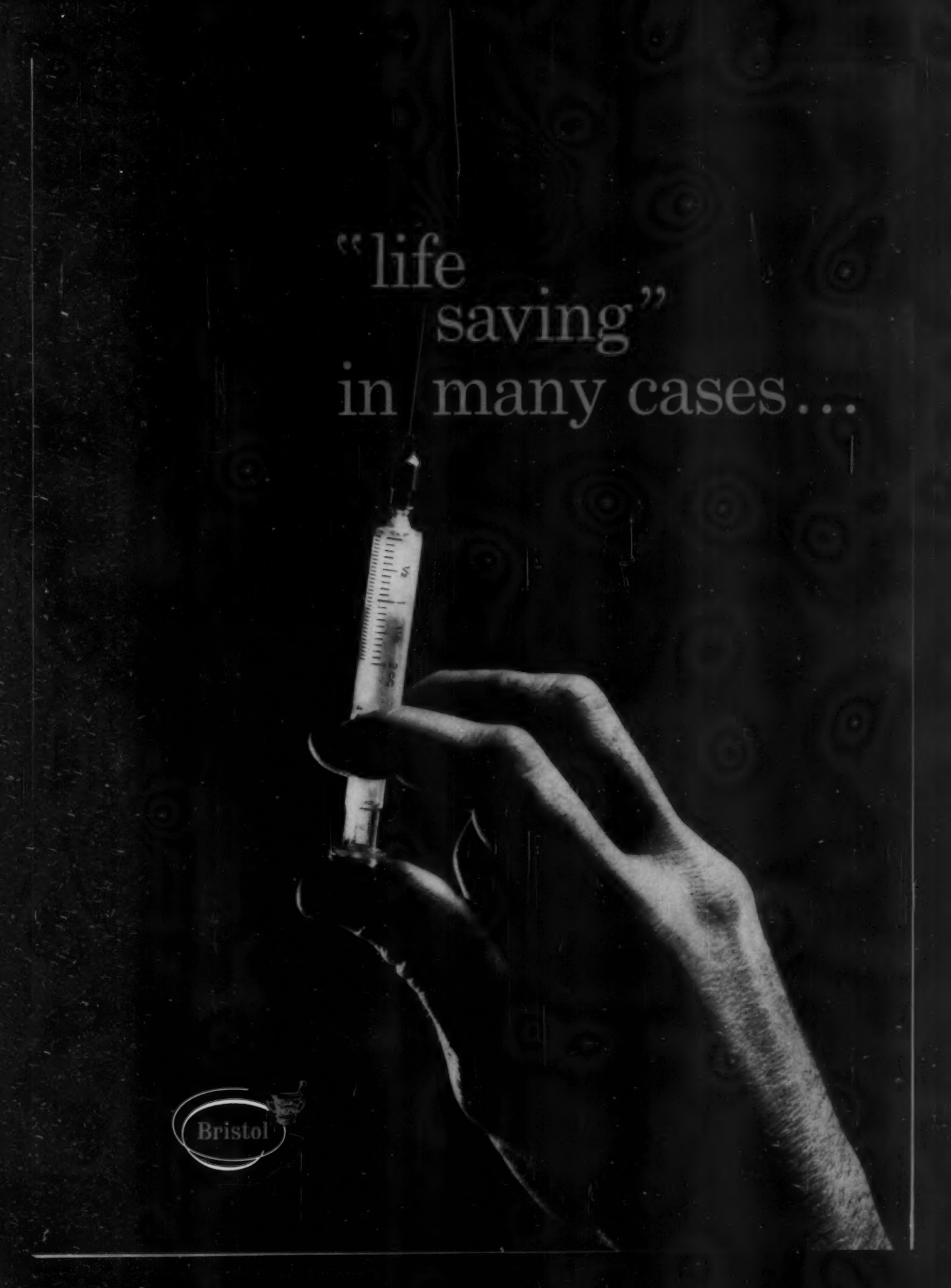
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REFERENCES: 1. Yow, E. M.: Practitioner 182:759, 1959. 2. Yow, M. D., and Womack, G. K.: Ann. N. Y. Acad. Sci. 76:363, 1958. 3. Bunn, P. A., Baltch, A., and Krajnyak, O.: Ibid. 76:109, 1958. 4. Council on Drugs, J.A.M.A. 172:699, 1960.

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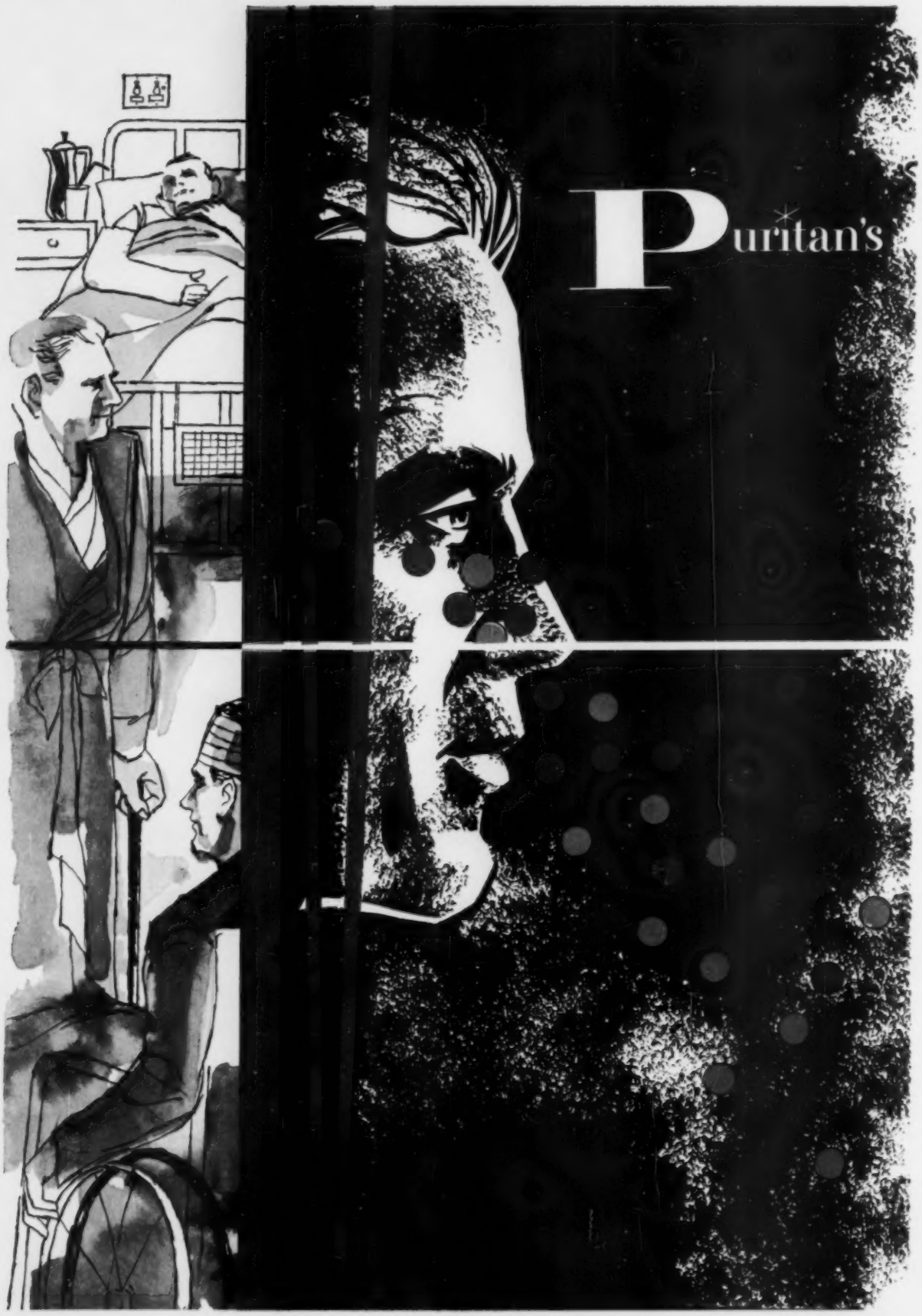
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1. Rainier, W. G., and Lee, B.: Hospitals, Jan. 1, 1957. 2. Kehlmann, W. H.: Med. Hosp. 84:104, May, 1955. 3. Hellman, L. D.: To be published.

Check List Offers Help in Administrative Planning

Question: I have read the articles on administration published in the various hospital journals, including the interesting series of articles in The MODERN HOSPITAL by Ray E. Brown. Do you have any other material available that could help us improve the administrative technics used at our 50 bed hospital? – J. M., Miss.

ANSWER: Harvey Schoenfeld, director of Barnert Memorial Hospital, Paterson, N.J., has developed a check list for use in administrative planning that might be especially useful to you. Mr. Schoenfeld reports that the check list has been effective at Barnert Memorial Hospital and with supervisors in other hospitals in the New Jersey area.

The check list, he points out, "appears to be most helpful in that it tends to remind the problem solver or project handler about all aspects necessary for a complete job. It also avoids one of the causes of administrative failure – the forgetting of a vital element until it is too late."

Here is Mr. Schoenfeld's check list:

	Yes	No
Is the purpose of the plan, policy, procedure, order or meeting understandable?		
Have I stated the reason, or need, for the action in my plan, policy, procedure, rule or order?		
Do I understand the scope of the plan? The project? The action?		
Have I written the plan clearly, concisely, completely?		
Am I expressing it so it is understandable to those who must accomplish the work and obtain results?		
Have I considered the ramifications of the plan?		
Have I considered an alternate plan, if necessary?		
Does my plan indicate who is involved?		
Have I consulted as many of those involved as possible in my planning?		
Have I carried out my part of the plan, or project, if necessary?		
Have I notified all concerned directly of their responsibilities in the action, the plan, or project?		
Have I determined how each step will be accomplished?		
Have I obtained the necessary clearances from supervisors and colleagues for each step, if necessary?		
Have I determined the necessary equipment and/or supplies and arranged for their presence?		
Do I know where the action will take place?		
Have I indicated it in my directive, memo, policy or procedure?		
Have I cleared the use of the area?		
Have I arranged for necessary seating, heating, air conditioning, ash trays, chalkboards, chalk, and so forth?		
Have I determined the date of the action?		
Have I determined the time of the action?		
Have I established a time schedule, if necessary?		
Have I established a deadline, if necessary?		
Have I cleared the time needed with all concerned?		

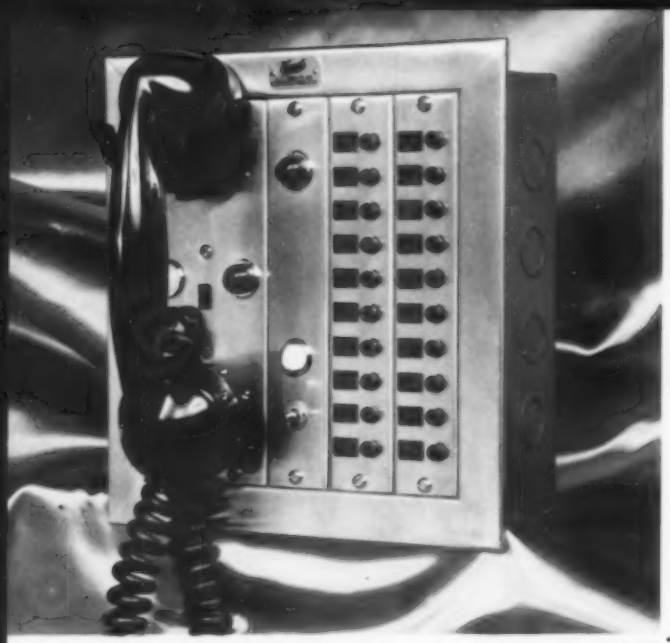
Plans are carried out by people who need guidance and leadership. The job of the supervisor is to provide intelligent leadership and knowledgeable guidance to subordinates. In order to ensure success for results in order giving, or the administration of plans, it requires follow-up through such questions as these:

1. Am I receiving reports of progress of plan or accomplishment of order given?
2. Am I personally observing the progress of the plan?
3. Am I evaluating the performance? – HARVEY SCHOENFELD, *director, Barnert Memorial Hospital, Paterson, N. J.*

ANY QUESTIONS?

The Modern Hospital will be glad to try to answer them.

If you have a problem or if you're just curious about a procedure or a statistic, please feel free to write this department, care of The Modern Hospital, 919 North Michigan Ave., Chicago 11.



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HUGE HEALTH INSURANCE PLAN STARTS

Next July 1 the world's biggest voluntary health insurance program will get under way. It is the plan that will offer protection to 1.8 million federal employes and their 2.2 million dependents.

But the program won't have smooth sailing, not for a while. Individual workers and some of their unions already are complaining that the Civil Service Commission isn't getting enough coverage for the joint U.S.-employe money being spent. Some even argue that they are carrying effective insurance now and paying less for it than they will have to pay as their share of the new type of insurance. C.S.C. says "Nonsense" to such stories, but the complaints continue.

Under the new system, the U.S. will offer to pay $2.82 a month toward the premium for single employes, and $6.76 for family coverage, providing the worker matches this for the minimum policy. If he wants more protection, he pays the extra amount himself.

Writing in the "Washington Post," federal employe columnist, Jerry Kluttz, declared:

"With the kind of money available ($100 million from the U.S., $150 million from the employes), there's a feeling that much of it will end up in the pockets of the insuring firms and that doctors and hospitals will boost their rates to get a larger bit of it. . . .

"Talk is growing of an investigation of the program. . . . Some officials are convinced that a better health program at a lower cost could have been provided if the government had set up and operated its own program to cover all of its employes and their dependents."

Regardless, it's now too late to change the arrangement before the July 1 deadline set in the law. Currently the commission is doing all in its power to educate the workers on details of the program. Two nationwide systems have been agreed upon, one under the direction of Aetna with a number of other commercial companies participating, and the other run by Blue Cross-Blue Shield.

Both systems offer both "low option" and "high option" coverage, with the employe paying more for the latter but receiving more in benefits. Because theirs are service plans, the Blues will pay directly to hospitals and doctors, whereas the commercial plans will pay to the insured.

As an example of variations, the Blues' low option will cost the U.S. $6.76 per month for family coverage and the worker $7.45. Costs under the high option will be $6.76 and $12.61 respectively. (For details, see article by Dr. Russell Nelson on Page 96.)

For family coverage, the Aetna group will charge the government $6.76 for low option, and the employe $6.76. The high option Aetna plan carries price tags of $6.76 to the U.S. and $10.70 to the worker.

Answering high-cost criticism, C.S.C. Chairman Roger W. Jones said a margin had to be allowed, as medical and hospital expenses are increasing and it will not be possible to reopen the two contracts and boost premiums for at least 16 months.

The commercial companies will be held to a profit of 1.3 per cent, which later will be reduced to 1 per cent. Because of higher administrative costs, the Blues will be allowed 1.5 per cent profit, with no future reduction. Agreements now are being worked out with numerous union plans.

TIME RUNNING OUT ON FORAND BILL

It's only May, but any discussion of the Forand bill for hospitalization under social security has to be pointed toward next November.

On this issue, the Republicans admittedly have been backed into a political corner. Some of them are trying desperately for a way out. Others — the rock-bound conservatives — would rather risk a party defeat in November than go along with any plan they regard as out-and-out socialism.

For months Secretary Flemming of H.E.W. has been telling the cabinet that the party has to sponsor a substantial program for the health care of the aged, and that perhaps it has to be under social security. At the showdown meeting, Flemming lost out. He was instructed to go back and "study the situation" in the hope of getting a compromise bill that would not involve social security and would not cost much.

But, as it developed, time had run out on him and the Republicans.

Before Flemming could work out another scheme and try to get it through the cabinet, eight Republican senators bolted the White House on this issue and introduced their own bill that did not have Eisenhower's blessing. That's exactly what Flemming had advised the party leaders would happen if a decision were delayed. A good party man, Flemming could not flatly endorse the senators' plan, but he went far enough to call it "a step in the right direction."

The Republican senators' plan would cost the U.S. about $480 million a year, the states $640 million, and participating individuals $400 million. Contracts carrying minimum provisions would be worked out with all states wishing to participate. The main feature is a sliding scale of premium payments by individuals. The very low-income people would pay nothing; a token payment would be demanded from those with modest incomes. If the income were adequate, the participant would have to pay the entire cost himself. It is estimated that the benefits planned would cost about $13 per month per person.

Whether this is a reasonable solution to the problem by now probably is an academic question. The Democrats,

controlling Congress, could hardly be expected to let the Republicans slip through legislation of this nature which could be exploited in the election campaign. At the best it is evidence that some Republicans are willing to act.

Flemming's modest proposal stands no more chance than the senators'.

Getting most attention now is a compromise being arranged by Senate Majority Leader Johnson and House Speaker Rayburn. Unlike other leading Democratic presidential aspirants, up to this time Mr. Johnson had not declared himself for Forand-type legislation. Early in the session Mr. Rayburn had said he didn't think the Forand bill would be passed this year, although he was careful not to declare himself for or against it.

This plan will involve social security payroll tax increases. It will cover hospital and nursing home charges, but not doctors' bills, possibly in an effort to dilute opposition of the American Medical Association. The Forand bill is similar, but does provide payment of some doctors' bills.

HILL-BURTON ASSURED ADEQUATE FUNDS

The Senate appropriations committee shortly will report out the House-passed money bill for the Department of Health, Education and Welfare, including money for Hill-Burton hospital construction grants. But, in view of comments from committee members, there's nothing much for hospital people to worry about. H-B is all but assured adequate money for the fiscal year starting July 1.

In the House, the Eisenhower Administration's recommendation for H-B was increased by $23.8 million to $150 million. While this is $36.2 million more than the program has to spend the current fiscal year, it is anticipated the Senate will add on still more, and may bring the total up to this year's.

In its report on the bill, the House appropriations committee came through with its annual criticism of the White House for not asking enough money for hospital construction:

"Any doubts concerning the complete inadequacy of the [Eisenhower] budget can easily be resolved by a simple review of the statistics regarding this program.

"As of Jan. 1, 1960, plans submitted by the state agencies show need for 845,402 additional hospital beds and 257,030 additional nursing home beds, or a total of 1,102,432. The funds requested in the budget, when combined with funds used for hospital and nursing home bed construction outside this program, will produce an estimated 43,628 beds, or less than 4 per cent of the additional beds which the states indicate are needed.

"State agencies report that if there were no limitation on federal funds they would have, during fiscal 1961, sufficient state and local matching funds to start work on 1020 projects costing a total of $1.2 billion, which would require Federal matching funds in the amount of $489 million.

"While the amount recommended by the committee is not aimed at filling all the existing needs it will certainly do a better job than the woefully inadequate budget presented to Congress."

For over-all Public Health Service expenses the House voted $876.9 million, $113 million more than the agency has this year and $29.6 more than the White House asked. Almost half the $113 million increase is represented by the $55 million increase in money for the National Institutes of Health.

Here again the committee squared off against the President:

"Before the hearings were concluded, it was apparent that the [Eisenhower] budget did not provide for advances nor even for a leveling off of the N.I.H. programs. It represented a retrenchment, a step backward, and it was so testified by the many public witnesses who appeared. . . ."

The Democrats say they are not just talking, but are preparing to pass this bill. Even if they don't they will have made the effort, something that the voters will hear about next fall. If the bill passes, President Eisenhower will be on the spot: He has repeatedly denounced any health care plan under social security, but a veto could cause great political damage.

Meanwhile, the New York Times reported that representatives of the A.M.A. and A.F.L.-C.I.O. will meet in Chicago this month for a conference on prepaid medical care. Blue Cross, Blue Shield, insurance companies and private welfare funds will also be represented in the "effort to find areas of agreement and improved understanding," the report said.

NOTES

Sometime after the May 20 Oregon presidential primary, in which he is running, Sen. Wayne Morse (D.-Ore.) has announced he will hold his long-delayed hearings on Blue Cross-Blue Shield insurance costs and other health issues in the Washington, D.C., area. He will look into all health questions, including drug prices and sales practices.

The Housing and Home Finance Agency has ruled that residents as well as interns may benefit from the intern-nurse housing loan program. This operation is lending $50 million per year for construction of apartments and dormitories.

Regulations for operating the Federal Housing Administration's mortgage guarantee plan for proprietary nursing homes provide for review of applications by state Hill-Burton authorities. While right of appeal is provided, it is regarded as likely that any home which doesn't qualify under the state's survey will not get the guarantee.

A new House bill would authorize $200 annual scholarship grants to student nurses studying for degrees. States or schools would have to put up between $50 and $100 for each grant. Only hospitals certified by the state would be eligible.

Pharmacists are disturbed over the nationwide popularity of mail-order drug sales. At its Washington meeting, the American Pharmaceutical Association condemned the practice as "a deliberate intrusion on the private practice of medicine and pharmacy."

ADMINISTRATION PLAN FOR AGED

An administration-approved plan for health care of the aged was presented to the House Ways & Means Committee by Secretary Flemming May 4. The plan would require $600 million a year of federal funds and a like amount from the states, to provide 180 days of hospitalization and other benefits for qualified low-income persons over age 65, it was explained. Beneficiaries not on public assistance rolls would pay a $24 a year premium.

The Modern Hospital
MAY 1960

LOOKING AROUND

Kitchen Kandinsky

THE children's ward at St. James' Hospital, London, has been decorated with abstract paintings instead of the usual cartoon characters, a British medical journal reported. Abstract art provides the bedridden patients with "an unending focus of interest," the pediatrician in charge explained. Answering a critic who thought some of the weird shapes might be frightening, he added: "I don't believe these pictures would engender nightmares."

Well, the children haven't been frightened, as it has turned out, but they aren't exactly fascinated, either. Asked what he thought about one painting, a seven year old patient said: "It's like kitchen wallpaper. We got some at home."

Surgeons' Progress

HOSPITAL administrators, trustees and physicians who are worried today about accreditation standards, surgical privileges, fee splitting, medical records, prepayment plans, radiologists, pathologists, emergency service and public relations may be either comforted or discouraged, according to their natures, to learn that hospital administrators, trustees and physicians have been worrying about all these things for twenty-five years and some of them for fifty — or at least since 1913, when the American College of Surgeons was founded. As everyone who has anything to do with hospitals knows, the College was largely the brainchild of an energetic Chicago gynecologist, Dr. Franklin H. Martin, who a few years earlier had established the journal *Surgery Gynecology & Obstetrics* and, later, organized the Clinical Congress of Surgeons of North America, which became the annual Clinical Congress of Fellows of the College. As everybody knows, too, it was Dr. Martin and his early associates in the College who first recognized the need for improvement and standardization of hospital practice; while the American Medical Association ground its teeth and the American Hospital Association studied its fingernails, they went ahead and began inspecting and approving hospitals.

However, not everybody knows how tough it was in the beginning. The *California State Medical Journal*, for example, ridiculed the whole concept of the College, and a branch of the Chicago Medical Society — then as now, apparently, a hotbed of judicial calm — described the College in a resolution as, among other things, unAmerican, undemocratic, unethical, unjust, inequitable, divisive, arbitrary, domineering and injurious. As soon as the hospital approval program was established, at considerable expense and pain, the College began to receive petitions from its own members calling for higher standards and better qualified inspectors. At about the same time, a state medical journal reported that critics were asking, "What right has the American College of Surgeons to standardize hospitals and set up rules and regulations for these institutions?" When a College committee issued a report mildly encouraging the earliest efforts of voluntary prepayment plans for hospital and medical service, the *Journal of the Indiana State Medical Society* said the American College of Surgeons had "come out for group hospital and medical insurance and consequently socialized medicine."

These and other obstacles the College has jumped over, knocked out of the way or slid around in its near fifty-year history of medical rough and tumble are described in a lively narrative that has just been published by a surgeon who wasn't on hand for the landing but was in the second wave, so to speak, and became a standard bearer in many of the later battles, which were no less colorful and exciting than the early skirmishes.* Accounts of the later episodes gain a certain spiritedness from the fact that the narrator was also a participant. Dr. Davis is at his best when he is telling about the latter

*Fellowship of Surgeons, A History of the American College of Surgeons, by Loyal Davis. Pp. 525. Price $10.50. Springfield, Ill.: Charles C Thomas Publisher, 1960.

day fights against fee splitting and the angry rash that broke out all over the medical profession whenever Dr. Paul R. Hawley, director of the College, or Dr. Davis himself, sounded off in public on the subject of medicine's besetting sin, as they did right along and, it turns out, as their predecessors in the College had done — with about the same results. Dr. Davis also writes with special gusto about the College's twenty-year war with the International College of Surgeons. These reports are fairly objective, all things considered, but the reader is rarely left in doubt about the author's sympathies.

Since the American College of Surgeons is primarily an educational association and not a species of mafia for surgeons, however, the history of course includes the record of its many solid accomplishments in raising standards of surgical practice, improving the education of surgeons, hospital standardization, care of trauma and cancer patients, surgical research, and stamping out sin among surgeons. Hospital administrators and trustees who have come to believe in recent years that improved public understanding of hospital problems is essential to any real progress in their solution will be especially interested to discover here that education of the public in the activities of hospitals and surgeons was one of the explicitly stated objectives of the College at the time it was founded, and one that was never lost sight of over the years. Forty years ago, the College was conducting hospital standardization conferences to which hospital trustees and representatives of chambers of commerce and businessmen's associations, as well as physicians and hospital administrators, were invited. The fact that these early efforts to inform the public about hospitals were not wildly successful was not due entirely to apathy or ignorance on the part of the public representatives, either. Most physicians at the time were horrified at these attempts to hold public discussions of what went on in hospitals. There was division of opinion about this aspect of the program inside the College and uniform opposition among physicians outside. To a great extent, there still is.

Ever since the Peloponnesian War, histories have suffered because historians were human beings, and Dr. Davis is just as fallible as Thucydides was. The account of events leading up to organization of the Joint Commission on Accreditation of Hospitals, for example, includes some chronological inaccuracies and omissions that are probably unimportant to everybody except the reporter who first broke the news that the College was about to relinquish the hospital standardization program it had supported for so many years with such distinguished success. A description of the Hill-Burton Act, ignoring the vast improvement in hospital service for the nation that it unquestionably has accomplished, blows up the fact that some of the new hospitals are poorly staffed into a sweeping condemnation of "the theorists who believed that bricks and mortar made a hospital."

Never a man to hide his own opinion beneath his operating gown, Dr. Davis sometimes plays advocate and judge as well as historian. Martin, Kanavel, Mayo, Crile, Ravdin and other Regents of the College are his heroes. Except for Dr. Hawley, members of the College's administrative staff are obviously considered a lesser, if not peasant, class. Bowman, Crowell and MacEachern are given short shrift, considering the substantial contributions they made to College programs; other staff members get no shrift at all. A few Regents whom many have considered giants are neatly debrided by Dr. Davis, whose surgical skill is not confined to the operating room.

Another, and perhaps lesser, flaw is the occasional carelessness of the writing, which is innocent of any clear comprehension of the proper method for handling restrictive and nonrestrictive clauses and pockmarked with dangling participles, unattached modifiers, pronouns that haven't even a nodding acquaintance with their antecedents and near vocabulary misses like "flaunt" for "flout" and "unwieldly" for "unwieldy." A few sentences are hashed up beyond all recognition, as when the author refers to "misstatements which could easily have been proved right or wrong."

These annoying errors are not especially chargeable against Dr. Davis, who is a neurosurgeon by profession and cannot reasonably be expected to have mastered the refinements of syntax, any more than Carl Sandburg should know the technic of pallidectomy. But the publisher should hang his heedless head. This is an important book; it should not have been downgraded by nonprofessional editing.

Fortunately, most readers are no more aware of minor errors in grammar than most patients are of minor errors in surgery, and the effects of the former are usually as benign as the results of the latter are lethal. Along with his small failings as a writer, Dr. Davis has the large gifts of vigorous style, swift pace, colorful vocabulary and ability to evoke scenes and personalities in a way that many impeccable grammarians might envy. His history of the American College of Surgeons is an illuminating, instructive and entertaining account of how hospitals and surgeons got where they are today in our society. Hospital people shouldn't miss it.

Manners

HERE it is again — this little message in the mail, urging us to exhibit good manners. "In our day-to-day dealings with others, good manners involve little more than ordinary consideration and kindness," it said, "the same type of behavior we would like to receive."

As a long-time "please" and "thank you" and "after *you*" man, we couldn't agree more. But we couldn't *disagree* more with the rest of the piece. "Many jobs have been lost, many a promotion delayed because people forgot that being rude, or condescending, or thoughtless, has no more place in the business world than it does in social or family life," this said. "There are far too many people who seem to have forgotten how important good manners are in everyday living. They don't seem to realize what a poor impression they make on others through their actions — what they say, and how they say it."

Unquestionably, bad manners are difficult to live with. But bad intentions are worse, and the person whose good manners are simply a foil for protecting his job, or his promotion, seems to us to be guilty of bad intentions. If good manners are anything other than the outward reflection of inner grace and good feeling, keep your thank-you's and give us a kick in the shins.

HOW MUCH DO HOSPITALS SPEND ON CONSULTANTS?

CHICAGO. — How much do hospitals spend annually on nonmedical consultations? No one seems to know. One authority puts the figure at $20 million. Another experienced consultant says that it is probably closer to $5 million and "certainly not more than $10 million."

Are they worth it?

"Put it this way," one consultant told The MODERN HOSPITAL, "if I can't save three times my fee on a building project in the planning stage alone I feel I'm taking money under false pretenses."

When trouble beckons, a consultant can often help avert a crisis

What Consultants Do To Earn Their Fees

Richard T. Viguers

HOSPITAL administrators generally encourage wide use of medical consultations. They have ample precedent. The Joint Commission on Accreditation of Hospitals makes such consultations a requirement in certain situations, and the consultant has traditionally occupied an important place in patient care and medical education.

Administrators, however, are often guilty of not practicing themselves what they encourage in others. Although they recognize the benefits that are usually forthcoming from administrative consultations, they often resist such consultations — usually because they feel insecure about their own performance record or are afraid to expose their errors and failures.

All consultations are not helpful, nor can all problems be solved by consultants. In general, however, consultants can improve hospital operation. Administrators should be wise enough and courageous enough to recognize this and utilize appropriate consultation services.

Some administrators have good reason for being

Mr. Viguers is administrator, Pratt Diagnostic Clinic-New England Center Hospital, Boston.

What the Consultant Has To Offer

The consultant has several things to offer. First, he has time to study and analyze problems, gather facts, and work out proposed solutions. In many instances the administrator may be just as competent as the consultant but the administrator does not have the time to devote himself without interruption to the study of this special problem.

The consultant also brings special knowledge, skill and experience to the problem. If he does not have these, he should not be hired.

The consultant also brings an objective point of view. He has no special ax to grind. He is not out to "get" anybody nor is he especially friendly with anyone. He comes in as a trained, experienced and impartial worker, and his recommendations have this unbiased and fresh approach to a problem that the administrator often cannot duplicate.

Finally, the consultant brings prestige with his recommendations. Often the consultant will recommend something which the administrator has tried to get adopted for years, but the prestige of the consultant, the special relationship that he occupies with the board, and his skill in presenting the recommendation get it adopted. This is an important aspect and a value which should not be minimized. ■

How To Select a Consultant

Selecting a consultant is not any different from the procedure used by an administrator in selecting any important employe for the hospital or in selecting an architect or a general building contractor. The administrator should pick three or four consultants of the type that he wants based upon the experience of other hospitals. He can readily obtain the names of these by calling friends and finding out the men who have done a good consulting job in other hospitals.

The next step is to invite the three or four proposed consultants to visit the hospital for a full discussion of what is wanted.

Then the administrator should ask these consultants to write him a detailed letter of proposal covering their methods, their objectives, and their costs.

The cost should be a fixed fee. This is usually based on the consultant's estimate of time it will take to do the job. Most consultants are now getting from $100 to $150 a day, plus expenses. This is about the rate charged by the larger firms for the men they put in the field. Senior men may get more than this.

Beware of the consultant who holds out the bait of large savings, or very extensive benefits. There is no magic in consulting. Unless the hospital operation has been fantastically bad or crooked there will not be tremendous savings from the consultant. It is likely that there will be some savings and it is very likely that there will be improved service to patients and more efficient operation.

From the experience of the interview and the detailed letters of proposal, decision can be made as to the consultant who seems best, the consultant who seems to understand your situation best and seems most likely to be helpful. ■

THE IDEAL TIME

sour on consultants. Many of them are familiar with the high powered expert who develops his solution to a hospital problem while he is on the plane en route to the hospital for the first time. This expert spends only long enough at the hospital to gather a few facts to illustrate his preconceived notion. He then departs to write a voluminous and spectacular report which is of little value and quietly gathers dust. This is not consulting. This is writing a thesis — a proposition laid down to be proved against attack.

The true consultant arrives at the hospital without preconceived or pat solutions. He brings along his experience, his knowledge, and his analytical ability. He seeks to study the situation in order to define the problem, and then to counsel together with the administrator, department heads, and others on the job to develop a solution which is acceptable to those concerned as being workable, practicable and timely.

The key concept is counseling together. This is the basis for developing a solution which is sound, which is understood, and which will be implemented by the man on the job.

The ideal time to call on a consultant is when things are going well in your institution. I cannot recall a time when everything was running smoothly in any hospital with which I was associated. But others may be more fortunate and if you do get to a time when things seem to be in comparatively good shape, this is often the time to call in a consultant.

At least once every five years I believe a consultant should be called in for general review of the hospital operation. Another sound policy would be to have one department of the hospital studied each year. Funds spent for consultation services are funds spent for improvement of the hospital. I think it would be wise to

TO CALL A CONSULTANT IS WHEN THINGS ARE GOING WELL

spend at least one-half of 1 per cent of the hospital's budget for consultation services.

The situation in which a consultant is most frequently called and where the need is most obvious, is when the hospital is planning major construction. The hospital consultant does not replace the architect or the administrator but is a member of the team with the administrator and the architect.

Some hospitals are out of date before the doors open. Most administrators build one or perhaps two hospitals in their lifetime. They have little opportunity to profit from their mistakes. The hospital consultant is not necessarily smarter, but he has had the opportunity to profit from his mistakes and make use of his experience in advising on the building of many hospitals.

In most cases, the administrator does not have enough time to plan the construction by himself. Either the hospital operation will suffer during the planning and building period, or else the administrator will be busy running the hospital and will not devote enough time to planning the new hospital. A consultant adds an expert to the administrator's staff so that the administrator can do a better job both in carrying on the operation of the existing hospital and planning for the new hospital.

When a major alteration program is contemplated a consultant can be of real value. He can make some estimate of the community needs to see how well the alteration will enable the hospital to meet these community needs. He is also often able to prevent wasting a great deal of money. Recently a consultant was called in by the trustees to advise on the "modernization" of a hospital. They were planning to "modernize" a wing of the hospital which was a frame structure, built about 1900 — one of the most inefficient, unattractive firetraps in the state. It was obvious that the only way to modernize this wing was to tear it down and start over again.

In another state the trustees were planning to spend $100,000 to improve an existing hospital. Studies by an architect and a consultant showed that the hospital could not be brought up to modern standards by any renovation job and that the hospital was in an undesirable location. What the community needed was a new hospital on a new site.

There are many other situations in which a consultant can be used advantageously. When the medical staff is critical of the hospital operation or when the trustees indicate a lack of confidence, the administrator usually goes on the defensive immediately. He points out that his costs compare favorably with those of similar hospitals and gets out a lot of statistics and reports justifying what is being done.

This defensive course of action has its place, but there comes a time when the administrator should take an offensive position and should say to the trustees that he is most anxious to improve the hospital and believes that a consultant should be brought in so that all concerned can find out just where the hospital stands and how its operation can be improved.

In a situation similar to this, a hospital called in a firm of management consultants. The firm chosen was a large one which worked principally for large business and industrial corporations but which had an institutional section with competent per-

Disadvantages of Calling In a Consultant

The first disadvantage is that the administrator may be fired as the result of the consultant's visit. This does not happen often but it does happen. Most consultants refuse to take a job where the board merely wants the consultant to write a report which will result in the hospital administrator's being asked for his resignation. Most consultants refuse a job where the purpose is to evaluate the administrator. However, I am sure that every consultant has had the experience of board members getting him off in a corner and asking, "Now tell us confidentially and frankly, do you really think this administrator is doing a satisfactory job?"

A consultation is no better than the consultant. If the consultant does not have the necessary ability or experience, the results of his visit will be unsatisfactory. The consultant may come up with horrible recommendations and the administrator may be even forced to adopt them; the consultant may have no new ideas and may not come up with anything that is worth while in the way of new approaches to problems.

Whenever an outside consultant is brought in, he will take considerable of the administrator's time and there is always some disruption of the hospital's activities and unrest among department heads and employes who wonder just what is going on and why.

One more disadvantage is the cost factor. Consultations cost money. Some are more expensive than others but a consultation may be a major hospital expenditure. ■

What To Clarify

Before the consultant begins to work it is important to have some basic understanding with the consultant. The consultant should work as staff to the administrator. He should be brought into the hospital team and be considered a part of the hospital group.

There should be a fixed time schedule for the consultant. All consultations seem to take more time than one would think necessary, but unless there is a fixed time schedule things tend to drag and the studies become unduly prolonged. An infinite amount of time can be devoted to any study, but decisions should be made in advance as to how much time can be fruitfully devoted to the study.

There should be a full discussion of all findings and recommendations with department heads and the administrator, and the recommendations should be presented to the administrator before they go to the trustees. There should be an understanding as to whether a report is necessary and how extensive this report should be. In some cases the written report is entirely eliminated and the consultant proceeds with the installation. There should be an understanding as to whether the consultant is to install the new system or whether this is to be left to the administrator or the operating people.

Obviously, these agreements can and usually will be changed on a mutually agreeable basis as the consultation proceeds, but it is useful to have a general understanding of the way the work is to proceed as a basis of operation. ■

ONE REAL CRISIS IN THE HOSPITAL

sonnel for surveying schools, hospitals and similar agencies. The firm first did a general reconnaissance of the entire hospital operation and then made a report indicating areas in which it thought further studies would be of practical value. The firm was then authorized to proceed with detailed studies in the areas where it felt improvements could be made. The consultants worked with the department heads and all recommendations were discussed with and approved by the administrator before being put into the final report.

They made a basic study of the hospital organization and recommended that instead of having 12 persons report to the administrator, a streamlined organization could be developed so that only four persons would report to the administrator. They developed a complete revision of procedures in the accounting department with the installation of business machines and worked out a system of budget control. They also recommended a centralized system for the dietary department which, it turned out, was not practicable because the necessary equipment was not available. This study cost about $25,000. It was worth it.

This management engineering study had another important benefit. The report stated that in general the hospital was soundly organized and well and efficiently managed. A year later when the medical staff again repeated the charge that the hospital was inefficiently operated, the chairman of the board replied: "Gentlemen, we had a complete and detailed study of this hospital operation by one of the best management engineering firms in the country. Most of their recommendations have been put into effect and they said that in general this hospital was well and soundly administered. The administrator or the joint liaison committee will be glad to have any specific suggestions you can make which will improve the hospital but we will not waste time on general statements and unsupported charges of inefficiency and waste." With backing like this the administrator is in a much better position to do a good job.

A crisis situation often calls for a consultant, and a real crisis in the hospital is when the administrator is about to be fired. I remember one such situation in which a consultant was called in. After a relatively short and intensive study, he met with the trustees and was able to convince them that the administrator was doing a good job, that the costs of the hospital were in line with those of similar hospitals, and that the deficits were the direct result of the policies and standards adopted by the trustees. The consultant was also able to convince the trustees that the administrator could not possibly carry out numerous directives from individual trustees which were often conflicting, and that all directives to the administrator should come from the board as a whole.

A consultant cannot always save the administrator or prevent hasty and unwise action by the trustees. Sometimes the administrator does not deserve to be saved and other times the situation is impossible and the wise thing is for the administrator to resign, but there are a great many times when the consultant can do a real service for the administrator, for the board, and the community.

Another time to call in a consultant is when the administrator is overburdened with work. Probably every administrator has more work than he can do, but when he is so occupied with details of the operation that he does not have time to fulfill his management responsibilities it is time to call in the consultant. In a situation like this the administrator is usually too close to the problems involved to see what the problem really is. The consultant, looking at this situation with an objective view,

IS WHEN THE ADMINISTRATOR IS ABOUT TO GET FIRED

and with time to gather data and analyze the facts, may find that it is a problem in organization. He may find that it is a matter of delegation or he may even find that the solution lies in convincing the board that an assistant is needed.

Too many administrators do not realize when they have a problem. If they are snowed under with details, however, this is a storm warning and an indication that they should consider bringing in a consultant.

If hospital costs appear to be out of line it is a good time to consider bringing in a consultant. A consultant may be able to suggest ways to cut costs, or he may report that the costs are entirely reasonable and the real problem is to find ways to finance the deficit. On the other hand, the consultant might report that in his opinion the costs are too low and that they are low because the hospital is rendering inadequate service or has a low standard of care.

A consultant with specialized knowledge of new equipment can often be most helpful when the installation of such equipment is being considered. Many manufacturers have consultants available at no charge.

Then there are often special technical problems. For example, if patients are complaining about noise in the hospital the administrator can do a superficial job by walking around and listening to the noise. If he is to do a real job he should have someone come in who is familiar with this field and can make definite readings, do a careful analysis as to what causes the noise, and make recommendations as to how the noise can be abated.

There are specialists in almost every area of the hospital field. For example, suppose you have a problem of shortage of operating room nurses and you want to consider the use of technicians in the operating room. This is a place where a person specializing in this matter can come in and set up a training program. In the dietary department there are many consulting dietitians; this service is often available from a state department of health.

One area in which hospitals are becoming increasingly involved, where everyone agrees you need a consultant, including the American Hospital Association, is when administrators enter into any union negotiations or discussions with any professional or semiprofessional group that seeks an annual wage contract. Here the average administrator would be wise to call in, at the very start, a man skilled and experienced in union negotiations.

Another situation in which many experienced administrators call for a consultant or a management engineering survey is when they are undertaking a new job. This is particularly true when the trustees have not been satisfied with the general operation of the hospital and where they expect rapid improvement to be made. In addition to giving the administrator another expert with whom to talk things over, the consultant can significantly speed up the studies and also will take some of the onus of change from the new administrator.

These, then, are a few illustrations of situations in which an administrator should consider calling a consultant. The significant point is that the administrator should be able to recognize when he has problems. When he has a problem he should do something about it. One of the ways of doing something about it is to call in a consultant. This is a normal and recognized practice in business and I believe it is becoming, and should become, a normal procedure in hospital administration. ■

Administrator Must Set the Stage

The administrator has some responsibilities, some things which should be done before the consultant begins his work.

In the first place, the consultant should have a place to work. This does not have to be fancy, but it should be a place where the consultant can be undisturbed and where he can talk privately to people. He needs a desk, a table, and a file which can be locked.

Second, the administrator should have a series of discussions with the medical staff, with the department heads and other employes to explain that the consultant is coming, what the consultant is going to do, and what he is not going to do, so that cooperation can be obtained from everyone.

Third, the hospital administrator should set a climate for the consultant and an example of cooperation and working with the consultant. The administrator's approach and attitude is quickly picked up and copied throughout the organization and if the administrator wants to get the most from a consultant he will show by his own attitude that the consultant is there to work with the hospital employes and to contribute to the improvement of the hospital.

The administrator, the staff and department heads, however, should do more than cooperate with the consultant. They should work with the consultant. The administrator should not sit back and wait for the consultant to come up with the answer. If consultation is "counseling together" then the administrator and his staff must really work with the consultant — counseling together requires working together.

The waiting room above with its novel design affords entry to hospital lounge and office. Wrought iron was used for benches and chandelier.

OUTLINE OF CONSTRUCTION COSTS

Total project cost	$1,700,000*
No. of beds ... 120 (planned for 60 additional)	
Cost per bed	14,000*
Total square feet	40,000
Cost per square foot	30
Total cubic feet	380,000
Cost per cubic foot	3

*Includes cost of Group I, II and III equipment and site.

Color Scheme Is in Harmony

PROGRESSIVE ideas on both interior design and patient care characterize the 111 bed Flatbush General Hospital, Brooklyn, N.Y., which was opened last August.

On the premise that color has an important psychological effect on the patients, the designers selected hues and tints that would create an atmosphere of warmth and lightness. White has been banished entirely from the decorative scheme, and green is the "least used" color, the builders say.

Colors range on each floor from blues to reds to orchids, and the draperies and bedspreads in patients' rooms have been coordinated with the color of the walls.

Murals have been used at strategic locations to brighten the lounges and corridors. One of these, shown in color on this month's cover, depicts clowns juggling gaily colored balls. Another mural is located in an alcove on the second floor opposite the children's ward. The scene, painted on a soft red wall, shows an old-time country fair.

Patients and visitors enter the hospital through a rotunda-shaped room that is lined with Pompeian green wrought-iron benches. The room is further ornamented by a handsome wrought-iron chandelier.

Color has been carried throughout the hospital — into the "back of the house" as well as the front. The staff dining room offers soft tints of pink and lavender in chairs and tables, with blending murals and mirrors on a soft green background.

In the kitchen, stainless steel and aluminum equipment glisten against beige tile walls.

Colorful wall hangings and other appointments carry out the modern look of the hospital in this informal waiting lounge.

Soft tints of pink and lavender were used with murals and mirror to decorate staff dining room.

With Progressive Plan of Patient Care

The hospital, which was designed by Wechsler and Schimmenti, New York architects, and built and owned by Dworman Associates of New York, consists of three floors and a basement. Each floor is divided into two wings.

The central section of the first floor contains executive and business offices. The operating room suite, consisting of three operating rooms and a postoperative recovery room, occupies one wing of the first floor. The other wing has accommodations for 19 patients. The second and third floors each contain 46 beds, with men patients housed in one wing and women in the other.

The structure lends itself to a modified progressive patient care program, according to Dr. Samuel L. Berson, executive director. A recovery room that has accommodations for five stretcher beds is incorporated within the operating suite to which virtually all postoperative patients are brought. This unit has one registered nurse on duty at all times. The patient's stay in this area is determined by his condition, and his discharge to his room or to the intensive care section is decided jointly by the surgeon and the attending anesthetist, Dr. Berson states.

The 19 bed intensive care unit serves both postoperative and acutely ill medical patients. All patients who are acutely ill on admission, *i.e.* those suffering from coronary thrombosis, bleeding gastrointestinal tract diseases, perforated viscus, severe burns, or other traumatic injuries that produce shock, are brought to the intensive care section.

The only other subdivision of the hospital besides the postoperative and intensive care units are the two floors on which routine hospital care is rendered, according to Dr. Berson. Thus far, the hospital has found no need to provide chronic disease or convalescent care.

"Our experience with progressive patient care," Dr. Berson says, "has led us to the conclusion that there are some problems in the administration of this program in the small institution. However, our ability to concentrate a greater percentage of highly trained personnel in the necessary area is an advantage in view of the present shortage of this type of professional help. We believe that the program has a great deal of merit and can successfully be adapted to institutions of 100 beds and over." ■

This Planned Salary Program Gives All Employes a Fair Share

Paul H. Keiser

I KNEW the minute my secretary told me Susie wanted to see me that there could be but one reason for her coming to my office.

As Susie entered I could tell that it had taken her several days of thinking and planning to build up courage for this outstanding event in her life. She started out hesitantly by saying, "I talked to Miss Henderson about this and she said that if I wanted an increase in salary I'd just have to talk to you about it." Susie went on to say, "You know, I'm not one to complain but . . . the way prices are going up on everything, including the increased bus fare, I just feel that I should be making more than 68½ cents an hour. I didn't feel so bad until I was talking with Mary and found out that she was making 83 cents an hour . . . and you know I've been working here at the hospital three and a half years longer than Mary has. You know, that just doesn't seem right!"

Now, just what can an administrator say but, "Well, it isn't right!" On the other hand, what are you going to do about it?

If you give Susie an increase in pay and bring her up to Mary's level, then you will also have to do something for Dorothy, Sally, Virginia and everybody else. One could go on and on and relate other situations in other departments aside from housekeeping, but it seems logical to assume that you've heard of some hospital, some place, that had a problem similar to this. If the employes were not talking to the administrator, the supervisors from each department were in to talk with him at least once every day. It got so that to be administrator of a hospital you had to be an expert in the art of side-stepping the issue.

The majority of hospital administrators without a doubt show great concern toward the expenditure of dollars for supplies and equipment. They also desire in most cases to spend a minimum amount for salary increases. But the number of administrators who show concern for the total dollars being spent for payroll seem to be a minority.

Job Appraisal Is Needed

A sound wage scale for the organization can be reached only through correct appraisal of the work elements of each individual job. To achieve such appraisal is one of the purposes of job analysis and job evaluation. Applying job evaluation principles then makes it possible to use a plan in the hospital which can be understood by most of the personnel. Secret pay increases then become unnecessary. Confidential salary policies no longer need to govern every personnel action. With *accurate* and *up-to-date* job classification there is a *reason* behind salary administration.

At Burlington Hospital, Burlington, Iowa, we recognized long ago the need for an organized, systematic approach to the evaluation of jobs toward the development of a fair and equitable salary plan. However, we also recognized that we could not resolve these needs or problems without special assistance. The cost of such consulting services precluded that course of action in the past. We were therefore pleased when we learned that we could participate in one of the pilot studies undertaken through joint sponsorship of the Council on Administrative Practices of the Iowa Hospital Association and Hospital Service, Inc., of Iowa. The time consuming work preliminary to the installation of this program has been completed, but we are not unmindful of the long time it will take fully to implement an over-all program of wage and salary administration.

Even at this stage, however, the study has eliminated, or at least more clearly defined, some of our personnel problems. The approach of the Basic Abilities System of Job Evaluation (see chart)* which was followed is quite new to hospitals in general. We are confident that it will be as successful for the hospital field as it has been in business and industry in recent years.

One might ask at this point, "Is it worth all the time and effort?" This certainly is a good question, for such

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*The Basic Abilities System of Job Evaluation was written by Ralph W. Ells, and was published in the Wisconsin Commerce Reports, Volume III, No. 2, June, 1951. Reprints are available from the school of commerce, Bureau of Business Research and Service, University of Wisconsin, Madison. The chart is an adaptation of one appearing in an unpublished manual on "Job Evaluation and Salary Plan" prepared by the Community Welfare Council of Milwaukee in 1954.

It is better to bring salaries into the open

with a sound wage program than to sidestep employe

complaints and pretend inequities don't exist

a program does require a considerable amount of time and effort on the part of the administrator, each individual department head, and the majority of the employes in the hospital. It also requires complete cooperation and interest on the part of the hospital board of directors.

The administrator of the hospital must first decide whether he is interested in job evaluation and the installation of salary standards for his organization. If he has any doubts about it, then he'd better give it further consideration. Once the administrator is convinced that this plan would be advantageous for his hospital, he must pass on his interest to the directors or supervisors of the various departments. This must be done as an informative selling program. These key departmental personnel will be called upon to devote their wholehearted support and understanding toward the completion of such a project.

Finally, communication to the entire personnel group must also be well organized and presented. Whenever one mentions job requirements, salaries or other personnel practices to an employe he creates an atmosphere of possible insecurity for the individual.

It must be stressed that this is a program that will provide only bene-

Nonprofessional Employes Are Separated Into 10 Salary Grades

Salary Grade	Minimum	Normal	Maximum	Job Titles
10	$450	$550	$650	None
9	375	462	550	Business manager; food service manager
8	300	360	420	Chief engineer
7	250	300	350	Credit manager; executive housekeeper; laundry manager; chief painter; medical secretary, and office manager
6	210	255	300	Cashier-bookkeeper, hostess, purchasing agent, secretary, painter, maintenance engineer, maintenance man
5	180	220	260	Admitting clerk and switchboard operator; cashier; hospital admitting clerk; insurance clerk; cook; medical records clerk; librarian assistant, nursing school; office assistant and laboratory aide; senior laboratory aide, and office assistant; clerk typist and office assistant
4	160	195	230	Telephone operator; assistant dietitian; washman; housemother, nurses residence; orderly II; laboratory aide and tissue technician
3	145	175	205	Assistant cook; assistant cook, special diet; diet clerk; extractor operator; aide, central supply; floor clerk; nurse's aide; orderly I
2	135	160	185	Dishwasher, machine; kitchen helper; maid; porter; laundress; linen room attendant; microfilming clerk; aide, obstetrics; aide, operating room; maid, nurses residence
1	125	145	165	None

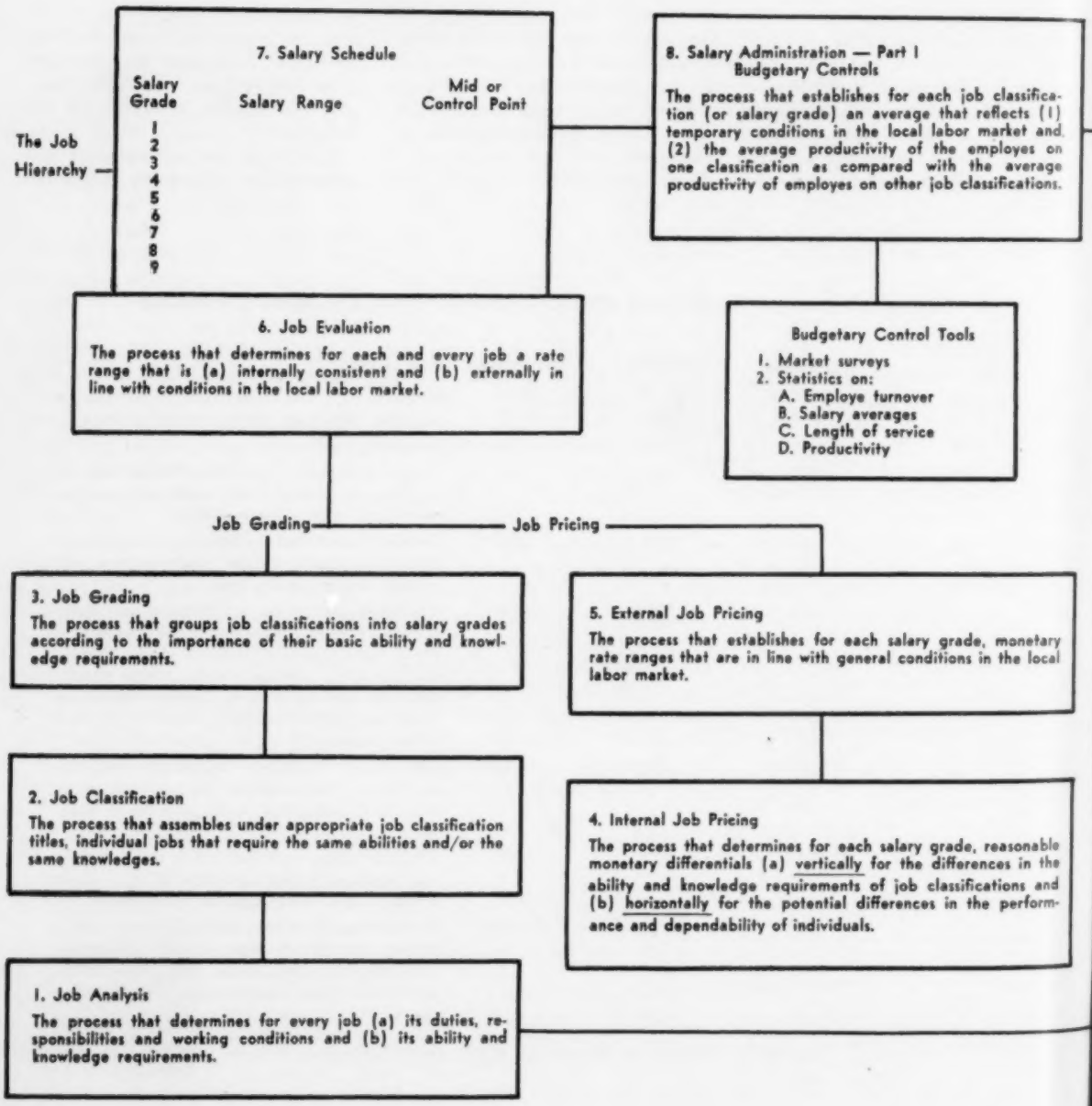
(A similar schedule for professional workers appears on page 92)

fits for the employe. It is important for employes to understand that a job evaluation study is simply a systematic method of determining the relative worth of each of their jobs, and then translating these appraisals into a fair and equitable salary program for all. They should be informed that no employe will receive a reduction in salary.

The actual processes that were involved in this wage and salary program are presented in the accompanying chart.

In addition to the actual processes and procedures there are several minor considerations that implicate the administrator. The first area is that of the *time* requirement. Time as we all know costs money, and when key personnel is involved this cost increases rapidly. In our case, all of our 200 employes were interviewed individually. Then I met with the department heads; next I reviewed the findings with the study directors; then I reviewed *these* results with the department heads, and then with the study directors. At the same time we found that new jobs were

CHART SHOWING PROCESSES FOLLOWED IN ADMINISTRATION OF SALARY

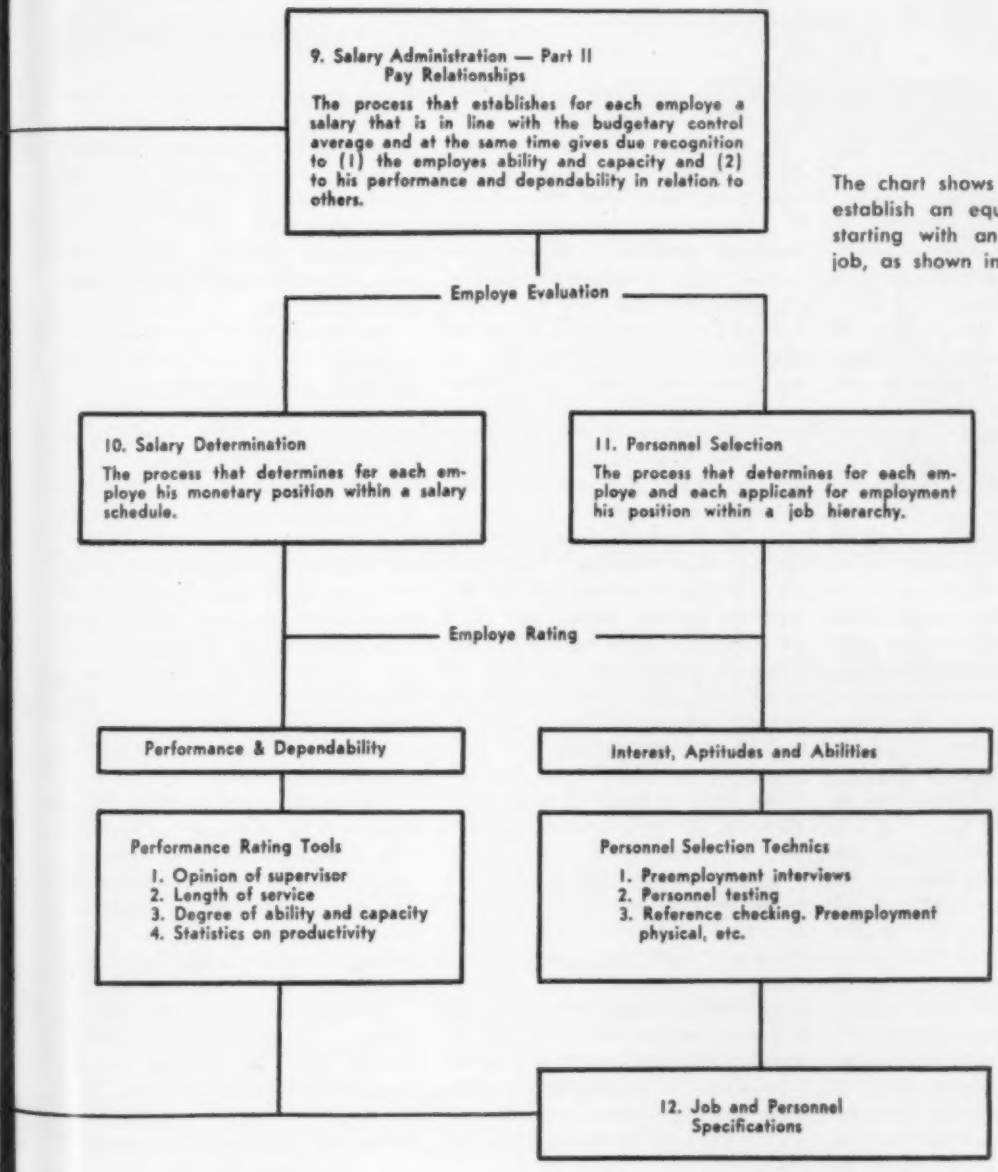


being created and installed more rapidly than we could get the job descriptions written.

Job description questionnaires were distributed to all employes at preliminary group meetings. These employes were encouraged to list and describe all of the tasks or work activities they performed, as well as to supply other information requested on the form. Several days after the group meetings were held, each employe was personally interviewed. The information supplied on the job description questionnaires was carefully reviewed and enlarged upon where necessary.

After all employes in a given department had been interviewed, conferences were held with the department head concerned. The purpose of these conferences was to ensure completeness and accuracy of the information obtained through interviews with the employes. Information was also obtained from department heads concerning the basic requirements for each position. These included the specific skills, knowledges and abilities that should be

PROGRAM AT BURLINGTON HOSPITAL, BURLINGTON, IOWA



The chart shows the steps taken to establish an equitable salary plan, starting with an analysis of every job, as shown in box at lower left.

Professional Employes Are Separated Into Six Grades

Salary Grade	Minimum	Normal	Maximum	Job Titles
P-6	$450	$550	$650	Director of nursing
P-5	360	435	510	Assistant director; nursing education; assistant director, nursing service; pharmacist; physical therapist
P-4	310	375	440	Medical record librarian; nurse, head; nurse, head, operating room; nurse, head, student health; nurse, instructor
P-3	275	337	400	Assistant head nurse, medical technologist II, nurse and x-ray technician
P-2A	240	290	340	Nurse, staff, general duty; nurse, staff, operating room
P-2B	225	275	325	Medical technologist I, x-ray technician
P-1	180	220	260	Nurse, staff, general duty (unregistered); licensed practical nurse

given consideration in the grading of jobs to a vertical scale, or determining their position in the job hierarchy.

Finally, conferences with department heads were also necessary in order to determine the personnel specifications for each of the jobs studied. A serious attempt was made to define personnel specifications in terms of realistic or minimum qualifications which would serve in the future as guideposts for personnel recruitment and selection.

In the system of job evaluation and job classification that was employed in this study, it was the ability or knowledge required to perform the job which was the determining factor in making vertical comparisons, or in determining the relative worth of the jobs. Information obtained from each department head included the basic abilities or knowledge required to perform each of the jobs under his supervision. Each ability or knowledge requirement was assigned to one of the following three categories or levels of skill –

Unskilled: Basic abilities that can be acquired in one to 30 days.

Semiskills: Abilities that can be acquired in from three to six months.

Skills: Abilities, which if they can be acquired, take at least 12 months or more in the acquisition.

The jobs were then graded primarily on the basis of these ability or knowledge requirements. Because of the salary differentials between professional and nonprofessional jobs, it was found most feasible to establish a supplementary schedule for professional job classifications.

As the study directors discussed the various job descriptions with the supervisors, they used the original job description questionnaires that had been completed by the employes responsible for each type of job. Discrepancies between what supervisors thought people were doing, or wished they were doing, and what they actually were doing were discovered at the time job analyses were discussed with the supervisors. These discrepancies had to be corrected so that an accurate current picture could be obtained and analyzed.

During the many weeks this study was in progress, proper information was distributed periodically to the employes so they would know that the program had not been disbanded. Salary increases were withheld or scheduled for later dates because we had decided to wait for the final results and act accordingly.

Once we reached a point at which tables could be made of existing salaries and the proposed salary scales, for the purpose of comparison, our business manager found that the tables became outdated before he completed them, because of the personnel turnover in certain departments.

Nevertheless, through the job evaluation technic employed we determined the worth of all jobs in the hospital in relation to the other jobs. Each job was assigned a specific salary grade with an established rate range, or what might be called a minimum and a maximum salary. We found that the salary some employes were receiving at this time was well in excess of the maximum rate that had been established for their grades. At the same time, however, we found there were numerous salaries that were well *below* the minimum salary rate for their jobs.

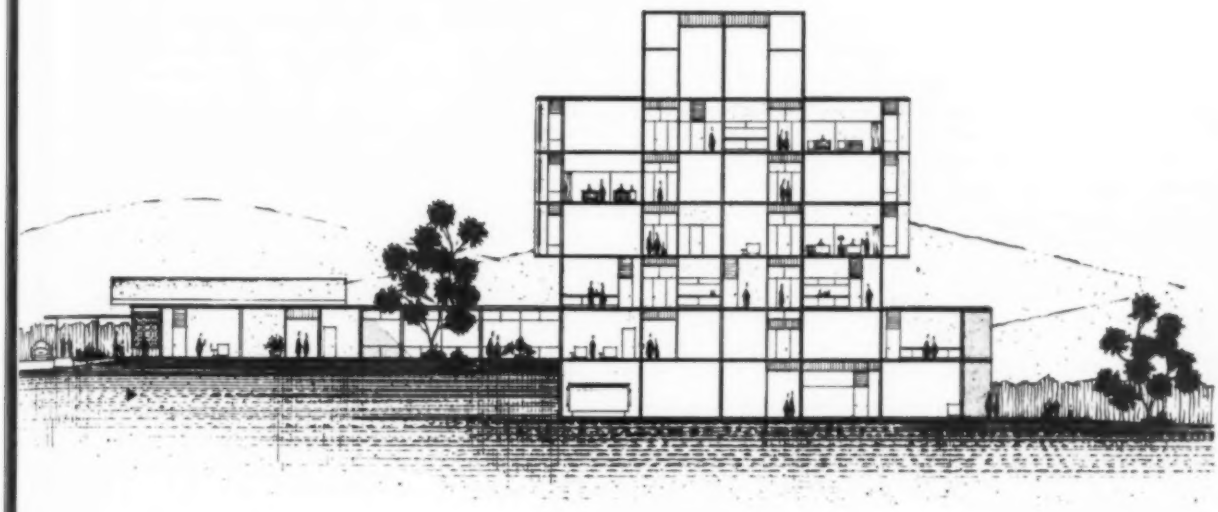
We decided that as a basic step, all employes who were below the established minimum salary grade to which they were assigned would have to be brought up to the minimum on the installation of the program

At the same time, we decided that it was imperative to install a 40 hour week for all employes. This helped the program in the thinking of the employes, for it then appeared to all as if the 40 hour week benefit came as a direct result of the wage and salary administration program. As it turned out, establishment of minimum salaries and the 40 hour week amounted to much more than we had originally planned.

The actual cost of installing the 40 hour week for all employes, however, was found to be rather inconsequential in relation to the benefits obtained from this change in policy. In terms of dollars it amounted to an annual increase in payroll expense of approximately $10,000, or about a 2 per cent increase in this expense. Bringing all employes to minimum salaries cost the hospital another $10,000 during the first year. Then during the second year when we effected our 5 per cent increase at six

(*Continued on Page* 172)

The Modern Hospital of the Month



Cross section drawing of Clark Field Hospital, Philippine Islands, shows staggered arrangement of floors made possible by new plan.

Balconies and Airy Design Give Lift to Air Force Hospital

BUILDING a hospital in the Philippine Islands, and an air force hospital at that, poses problems that are not ordinarily encountered in the civilian hospital in the United States.

Climatic conditions in the islands, the architects explain, dictated the need for air conditioning throughout almost the entire 200 bed hospital of Clark Air Force Base, while the tendency of the earth's crust in that part of the world to shift from here to there necessitated special structural provisions against earthquakes.

The hospital was designed by Belt, Lemmon & Lo and Isadore and Zachary Rosenfield, New York architects and engineers, in collaboration with the air force surgeon general's staff.

Because Clark Field Hospital serves the entire military community and other government personnel stationed in the Far East, the hospital is in a sense a community and referral hospital. As such, it contains all the usual hospital departments, except laundry, which is done centrally on the base. It differs from the average civilian hospital, however, in having a very large outpatient department (about 6000 square feet), a flight surgeon's clinic, and a dental clinic that contains 16 dental operating rooms and ancillary services.

(*Continued on Page* 94)

(*Continued From Page* 93)

The hospital is a five-story structure, the ground floor of which is one large square with an interior garden court. The spacious lobby-waiting room has a view to the landscaped grounds through the huge shaded wall of glass, and as the visitor continues to the elevators he will see the garden court which is to be used as an outdoor extension of the adjoining glass-walled patients' library and lounge.

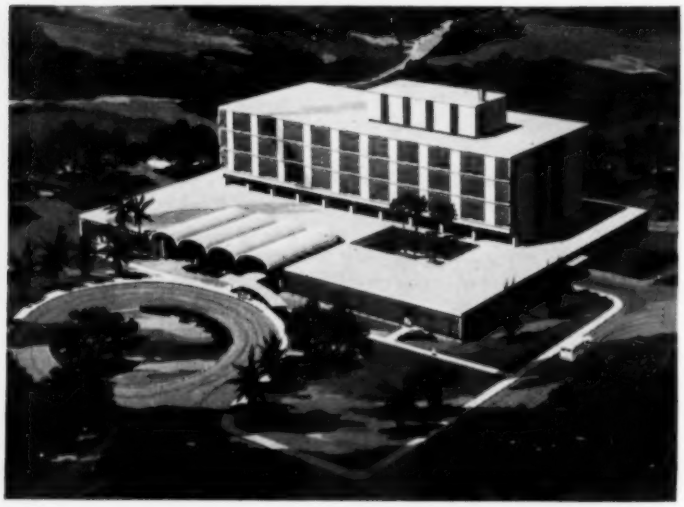
The second floor is devoted to surgery, delivery, cystoscopy and the related services. This floor is considerably shorter than the nursing unit floors above, a situation that gives the building an air of lightness which the architects believe adds to the attractiveness of the building.

The three nursing unit floors are arranged in double corridors, which results in shortening the building considerably in comparison with single corridor nursing units.

Describing the arrangement of the utility rooms, Isadore Rosenfield explains that "for the purpose of attaining a higher degree of discipline and asepsis," the utilities are arranged parallel to each other, each set of services for its own nursing unit. The nurses' stations are arranged for easy intercommunication so that at night one crew can cover both sides and, in an emergency, nurses can be freely shifted from one side to the other.

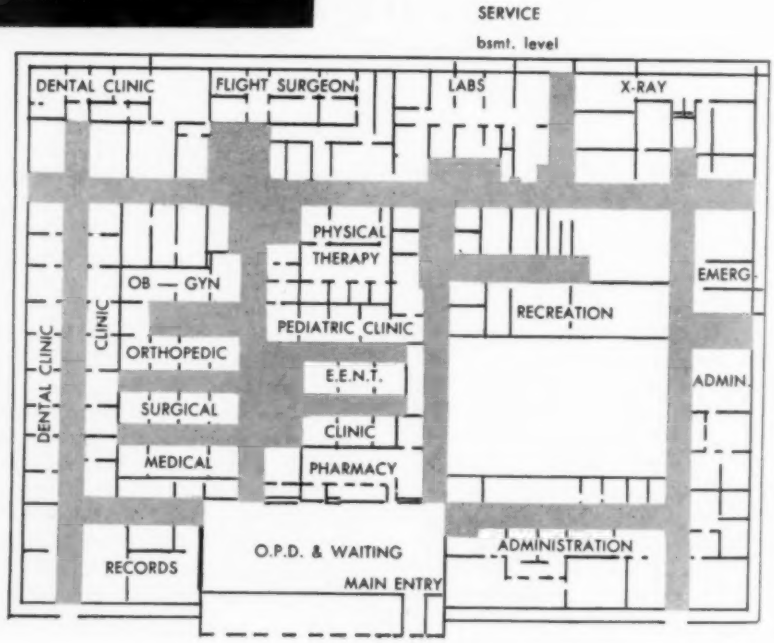
A typical floor, Mr. Rosenfield says, has about 70 beds, or an average of 35 beds per nursing unit. The ends of the nursing units nearest to the nursing services are intended for the more intensive type of patient care. The opposite end has from four to five identical four-bed rooms intended for intermediate care, or self-help, and the rest of the space is devoted to different special purposes on each floor. Thus, on the third floor the nontypical space is occupied by nurseries and the milk formula suite; on the fourth floor it is occupied by a neuropsychiatric unit, and on the fifth floor, by isolation suites.

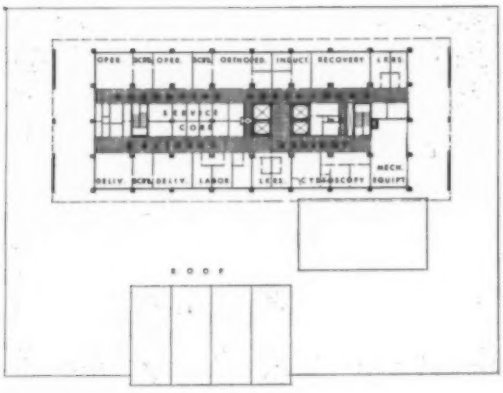
In addition to the lobby, garden court, and waiting areas, the ground floor houses administrative offices, the outpatient department, x-ray service, laboratories, physical therapy, emergency service, and recreation facilities for inpatients. All of these have been arranged for contiguity to satisfy functional relationships and to create clean and unmistakable lines of circulation, Mr. Rosenfield states.



Architect's rendering, above, shows how room balconies with sun screens add to appearance as serve practical purpose. Right: Ground floor is large square with an interior landscaped court.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital and the architects. A similar award will be made each month.





Second floor, left, is devoted to surgery, delivery, cystoscopy and related services. This floor is considerably shorter than nursing floors above it.

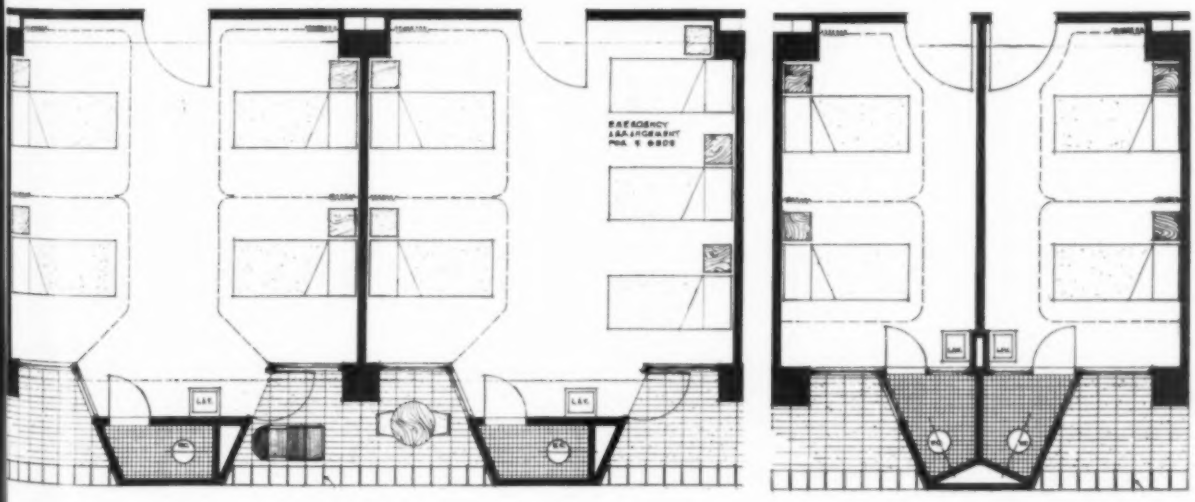
Two-Bed Rooms Have Space for Three Beds To Meet Emergency Needs

The available area per bed in patients' rooms is considerably greater than that of the average civilian hospital, the architects state. In case of need a typical bedroom can accommodate three beds where two are planned for normal conditions. The hospital therefore has a usable emergency capacity of about 300 beds.

The typical room layout is unusual in other ways, Mr. Rosenfield points out. In fact, it represents a radical departure from the conventional plan. Flexibility in arrangement, he explains, has been achieved by the placement of the toilet outside the rectangular room space.

In the conventional room, the toilet is near the corridor wall and, in addition to the space required by the toilet room itself, there is unavoidably a waste of space necessary to achieve passage past the toilet from the corridor to the bed. That circulation space saved in the Clark Field Hospital, Mr. Rosenfield says, has become a small, but useful, balcony for each room. The basic purpose of the balconies is to provide shade from the sun, and the addition of a little extra reinforcing steel has made the structures strong enough to carry the weight of the plumbing. ■

Drawing of typical four-bed room, below left, illustrates how room can be converted for five beds as emergency arrangement. Two-bed room, right, can accommodate three beds. Placement of lavatory aids flexibility.



Federal Workers Choose a Health Program

If they understand the options available, administrators can help federal workers select their health care benefits

Russell A. Nelson, M.D.

COME June, almost two million government employes will be picking a health program for themselves and more than two million of their dependents.

For most people, this kind of complicated choice is made by staffs of highly trained experts, retained by their unions or employers, who know how to read between the lines of a health insurance contract. But federal employes will have to choose for themselves.

Hospital administrators can, it seems to me, provide a service to federal employes in the communities they serve by understanding the differences between the available contracts and explaining these differences when opportunities occur.

The wrong choice between plans looking pretty much alike and even costing almost the same may leave many employes holding a considerable bag of extra out-of-pocket expense when they wind up in the hospital – and one out of every three families will be on the paying end of a hospital bill this year.

The things they'll have to know, or find out, between now and June are the basic principles of shopping for health care benefits that everybody should know, but few do.

That's why it is especially important for hospital administrators to be knowledgeable on this subject. The community has every right to expect informed guidance on such matters from the hospital, especially when they are discussed at meetings of service clubs and other community affairs at which the hospital is represented.

Here, for example, is a question that can mislead.

Is a program that offers $30,000 maximum benefits better than one that offers a top of $20,000?

The likelihood that anybody's hospital expenses will ever come within calling distance of either of these figures is pretty remote. The informed buyer will pay much less attention to the attractions of these top limits than to those less glamorous sections of the contract that describe what goes on inside – namely, just how much of his expenses will be covered under more probable hospital admissions whose total expenses run anywhere from $150 to $2000.

The overwhelming majority of federal employes will choose either the "Service Benefit Plan" (Blue Cross-Blue Shield) or the "Indemnity Benefit Plan" (commercial insurance companies). Both plans offer two levels of benefits, a High Option and Low Option. The high level provides coverage for longer stays in the hospital, bigger payments, higher maximums – and naturally costs more.

Whether to pick the high or low level, however, will be the federal employes' second choice. His first: service or indemnity.

Service plans, of course, are community nonprofit organizations that work through contracts and agreements with hospitals and physicians. Indemnity plans are private business corporations. Service plans do not pay dividends to stockholders. The difference in dollars and cents can be considerable.

For example, hospital room and board charges vary widely across the country – from $12 a day to $30. In the federal employe program, typically, the service plan expresses its coverage by number of days – the Low Option covers 30 days and the High Option covers 120 days without cost to the patient, regardless of room and board charges.

The indemnity plan makes a dollar allowance toward room and board – the first $250 plus 75 per cent over that on the Low Option, the first $1000 plus 80 per cent over that on the High Option.

In some areas, especially in expensive metropolitan centers, these indemnities will buy many fewer hospital days than in others.

Let's make the reasonable assumption that charges for room and board only are $20 a day:

Low Option Service
(for 30 days) . . $ 600.00 value
Low Option Indemnity
(for 30 days) . . $ 512.50 value
High Option Service
(for 120 days) . . $2400.00 value
High Option Indemnity
(for 120 days) . . $2120.00 value

(*Continued on Page* 206)

What the Service Plans Try To Do

There are things that don't get into a contract, but should be weighed. The buyer of health benefits ought to think about the *aims* and *approach* of the plan he decides to buy. Service plans try to meet, as fully as possible, the real and predictable needs of people. They depend on their close relations with doctors, hospitals and members to find voluntary ways of keeping costs down, quality high, and use of benefits reasonable and right. They do *not* try to achieve cost controls by putting such a load of deductible and co-insurance expense upon the first phases of an illness that the subscriber hesitates to seek treatment or denies himself needed care. ■

Dr. Nelson is director of Johns Hopkins Hospital, Baltimore, and president of the American Hospital Association.

What the Study Disclosed

The major findings of a study of the activity of the emergency unit at Beth Israel Hospital in Boston summarized here have direct implications for planning facilities and staffing services of the hospital emergency unit.

1. Trauma accounts for one-third of the cases treated in the emergency unit.
2. A wide variety of medical conditions comes under treatment, ranging from the most urgent to the purely elective.
3. One-fourth of the patients have made recent use of the outpatient department.
4. One-fourth of the patients are attended in the emergency unit by private physicians.
5. In their use of the emergency unit, private physicians treat a considerable proportion of nonemergent conditions. ■

How New Patterns of Medical Care Affect the Emergency Unit

Sidney S. Lee, M.D., Dr.P.H.; Jerry A. Solon, M.A. and Cecil G. Sheps, M.D., M.P.H.

Emergency rooms are enlarging their function to fit into the changing pattern of medical care, this study shows

THE increasing and changing use of hospital emergency facilities in recent years emphasizes the need for hospitals to do some basic stock-taking of their emergency units in terms of both physical planning and staffing.

The reasons for the marked growth in use of hospital emergency units are rooted in evolutionary changes involving hospitals, physicians and patients. The concept of the hospital has changed radically in a number of ways. At the same time, physicians' methods of practice have been altered both by technological influences and social change.

Physicians have become increasingly reliant on the hospital's facilities and resources, and are often less easily available for patients' calls. Taking their cue from these developments, people have been forming a broader view of the hospital as a personal medical resource. They have also been turning increasingly to the use of emergency units because of personal and economic considerations revolving around medical insurance provisions, arrange-

Dr. Lee is general director of Beth Israel Hospital in Boston and associate in public health practice, Harvard School of Public Health. Mr. Solon is director of the medical care studies unit of the hospital and instructor in medical care, Harvard School of Public Health. Dr. Sheps, formerly general director of the hospital and clinical professor of preventive medicine at Harvard Medical School, is now professor of medical and hospital administration at the University of Pittsburgh's Graduate School of Public Health.

This study is supported by a research grant under the Hospital Facilities Research Program of the U. S. Public Health Service.

Adapted from a paper read before the Medical Care Section of the American Public Health Association, Atlantic City, N. J., October 1959.

ments for private care, and outpatient department policies.[1, 2]

Concurrently, awareness of the actual and potential significance of hospital emergency services (which has been intensified of late by need for disaster planning) is arousing concern about the quality of the medical care provided in emergency units.[2, 4]

A changing pattern is also evidenced in physicians' use of the emergency unit to perform minor surgical and other procedures on a scheduled arrangement. Patients scheduled in advance or otherwise seen in the emergency unit for conditions that are less than emergent were in earlier years more frequently attended in the doctor's office.

That the emergency unit patients as a group are better situated socioeconomically than the patients of the outpatient department, as shown in our study, should not be surprising. The difference is of course largely induced by the administrative arrangements for the use of these services: Patients are screened in the O.P.D. to ascertain that their financial limitation warrants use of the outpatient clinics; no such restriction applies in the emergency unit, which is open to use by all.

Although fees may be scaled down in both according to the person's means, the eligibility determination draws a sharp line of distinction between the O.P.D. and the emergency unit. Furthermore, private practice frequently extends into the emergency unit, but not into the O.P.D. Thus, the public image of the hospital's emergency unit is quite different from its conception of the O.P.D. By and large, the typical urban O.P.D. is overlaid with connotations of indigency; it is an alternative for those who cannot afford to pay a private physician's fee.

The emergency unit is viewed as a proper place to obtain care under circumstances entirely divorced from financial considerations. The choice is in fact often made by the private physician himself, in directing his patient to the hospital emergency service, on the basis of *medical* indications, or of *technical* facilities, or of *personal* convenience for himself or the patient or both.

From 9.7 million emergency visits to hospitals in the United States reported for 1954, the number has grown to 18 million visits in 1958. To judge from this steep rate of increase and from some hospital studies, the greatest increases have taken place in the most recent years.[5] Figure 1, which traces the trend for Beth Israel Hospital in Boston, demonstrates a rather typical pattern.

A study of its emergency ward has been directed toward clarifying its present role in medical care.

Any patient who presents himself to the emergency unit is supposed to receive prompt attention. Care is provided by the house staff unless the patient requests a private physician or has come in by arrangement with his own physician who will attend him (the resident will, of course, meantime give necessary immediate care).

The emergency unit also schedules minor surgery to be performed in the unit. Ambulatory patients booked for special procedures to be performed outside the emergency unit — such as surgery, endoscopies, fluoroscopies, and castroom procedures — are received and discharged through the emergency unit.

Method of Study

The study is based on a retrospective sample of cases, with data obtained from patient records. The sample selected for study includes all patients who were attended in the emergency unit during four sample weeks. These weeks were distributed evenly over the first half of 1957 (weeks of January 13, March 10, May

[5]Shortliffe, Hamilton and Noroian, op. cit.

[1](a) Shortliffe, E. C.; Hamilton, T. S., and Noroian, E. H.: The Emergency Room and the Changing Pattern of Medical Care. New Eng. J. of Med. 258:20 (Jan. 2) 1958. (b) Kaplan, H., and Levinstone, B.: An Appraisal of the Emergency Room of the Newark Beth Israel Hospital. Journal of the Newark Beth Israel Hospital 10:113 (July) 1959. (c) Hospital Council of Greater New York: Emergency Department Services in Hospitals in New York City. Bull. of the Hosp. Council of Greater New York 14:1, 1959.

[2]Williams, R. D.: The Challenge of Emergency Clinics, editorial, Amer. J. Surg. 96:1 (July) 1958.

[3]Anon.: Surgeons To Study Emergency Service, Mod. Hosp. 90:67 (April) 1958.

[4](a) Grout, J. L., and Holub, L. A.: Twenty Years' Experience in Emergency Room Management. Bull. of the Amer. Coll. of Surg. 40:210 (July-August) 1955. (b) Lowden, T. G.: The Casualty Department: I. The Work and the Staff. II. Shortcomings and Difficulties. III. A Comprehensive Accident Service. Lancet 270:955 (June 16); 1006 (June 23), 1060 (June 30) 1956. (c) Tucker, R. W.: Jacking Up Hospital Emergency Rooms. Med. Econ. 35:166 (Sept. 15) 1958.

Setting for Study of Hospital Emergency Unit

The setting for this study is a voluntary teaching hospital in a metropolitan center. The emergency unit is organized administratively under a director of ambulatory services who also has responsibility for the outpatient department.

The emergency area is a ground-floor suite, easily accessible from a main traffic artery. It consists of a reception area and nurses' station, a waiting room for patients and relatives, five examination and treatment rooms (including one for E.N.T., and two with an observation bed in addition to the usual stretchers), two minor operating rooms, and a small laboratory for simple diagnostic procedures.

Laboratory, x-ray and other ancillary services are available around the clock from the appropriate hospital departments. Elevators lead directly from the emergency area to the main laboratories, x-ray and operating suite, all located two floors above. A connecting passageway leads to the outpatient department building. The observation beds in the emergency unit are designated for observation periods not exceeding six daytime hours or overnight. A small inpatient unit on an upper floor accommodates emergency admissions if inpatient beds are otherwise unavailable.

Two residents — one surgical and one medical — have full-time assignments to the emergency unit. The surgical resident is responsible for initial care of every patient, calling consultants or referring the patient to other services as required. On call are house officers in other specialties including pediatrics, obstetrics, otolaryngology, gastroenterology, urology, psychiatry and dentistry. Any other staff members may be called in as necessary, including the chief residents in medicine and surgery, full-time staff members, and visiting physicians. ■

5, and June 30) in order to provide seasonal representation. In all, 798 visits were included for study.

Data were extracted from the records, classified and coded, and processed by mechanical tabulation.

Findings

Age and Sex. The emergency unit is used by people of every age level (Fig. 2).

Nearly equal numbers of males and females come to the emergency unit (55 per cent female). However, males predominate at ages under 15 (63 per cent), while women predominate throughout the rest of the age range (averaging 57 per cent). This type of age-sex distribution parallels the pattern found in the total national volume of physician visits of all types.[6]

Socioeconomic Status. A rating of the person's area of residence was used for classifying socioeconomic status of the patients.[7] (The reliability of this method has been demonstrated in similar research applications.[8]) The patients were categorized according to ratings of the census tracts of the Boston Standard Metropolitan Area; these ratings were based on education and occupation characteristics of the respective populations of the census tracts.

Patients in the emergency unit at Beth Israel are drawn from every category of the socioeconomic scale. The contrast with those who use the hospital's outpatient department is distinct: The emergency unit's users are in relatively better circumstances than are the users of the O.P.D.

Relation to O.P.D. One-third of the emergency unit patients were found to have used the hospital's outpatient department within a year's period (Oct. 1, 1956 to Sept. 30, 1957) surrounding the time of the survey (January to July 1957). Only 8 per cent of the total sample first became known to the O.P.D. *after* emergency unit visits, while one-fourth of the patients had made recent use of the O.P.D. *prior* to their emergency visit. In addition to these recent users of the O.P.D., one-fifth of the emergency patients were known to the O.P.D. from use antedating the current year (*i.e.* prior to October 1956).

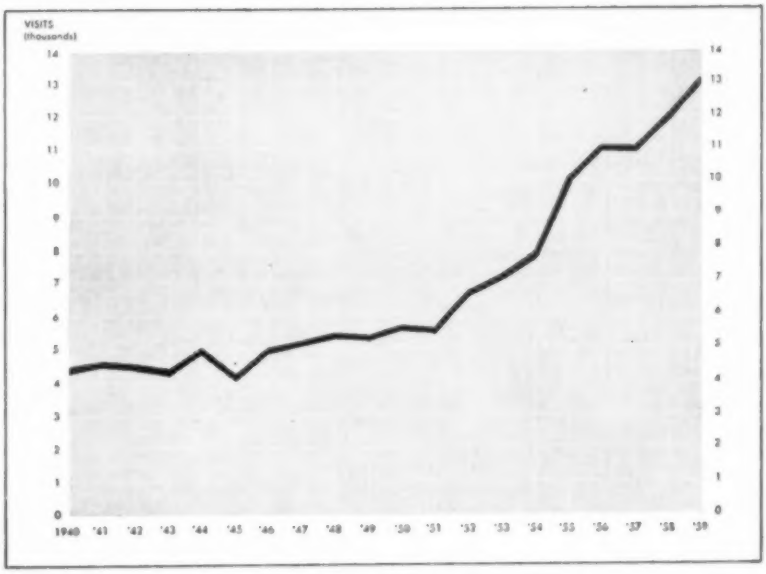


Fig. 1—Trend of visits to emergency unit, Beth Israel Hospital.

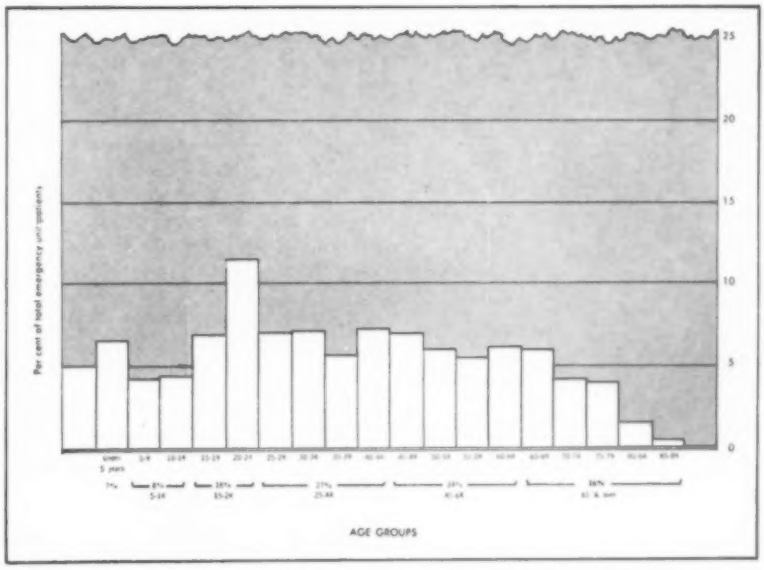


Fig. 2—Age distribution of patients using emergency unit, 1957.

Thus, more than one-half of the emergency unit patients are also outpatient clinic users at some time: 45 per cent prior to the current emergency unit visit, and 8 per cent first becoming known shortly after.

Private and House Service Cases. One-fourth of the patients are attended in the emergency unit by private physicians. Only 17 per cent of these patients had ever before been to the hospital's outpatient department, whereas 55 per cent of the house service patients had been there.

Within the year immediately surrounding the study period, the O.P.D. was used by 44 per cent of the house service patients, but by only 3 per cent of the private patients.

Urgency of Conditions. The extent to which emergency units handle emergencies or other less urgent conditions is a subject of much interest.

Figure 3 tells the results of this study at Beth Israel Hospital. Condi-

[6] U.S. Public Health Service: Preliminary Report on Volume of Physician Visits, U.S., July-Sept. 1957, series B-1, Health Statistics from U.S. Nat. Health Survey, Washington, D.C., 1958.

[7] Shevky, E., and Bell, W.: Social Area Analysis. Stanford, Calif.: Stanford Univ. Press, 1955.

[8] Rosenfeld, L. S., and Donabedian, A.: Prenatal Care in Metropolitan Boston. Amer. J. of Pub. Health 48:1115 (September) 1958.

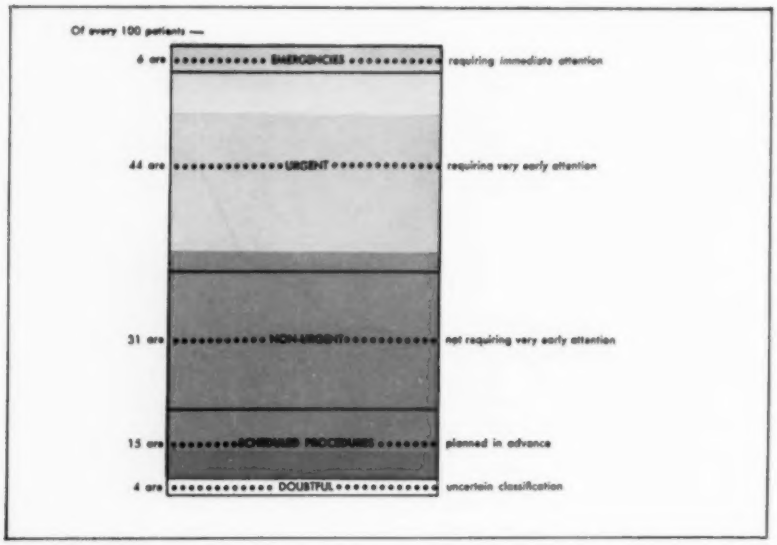


Fig. 3—Of patients entering the emergency room, 50 per cent were classed as emergency or urgent; 15 per cent, scheduled.

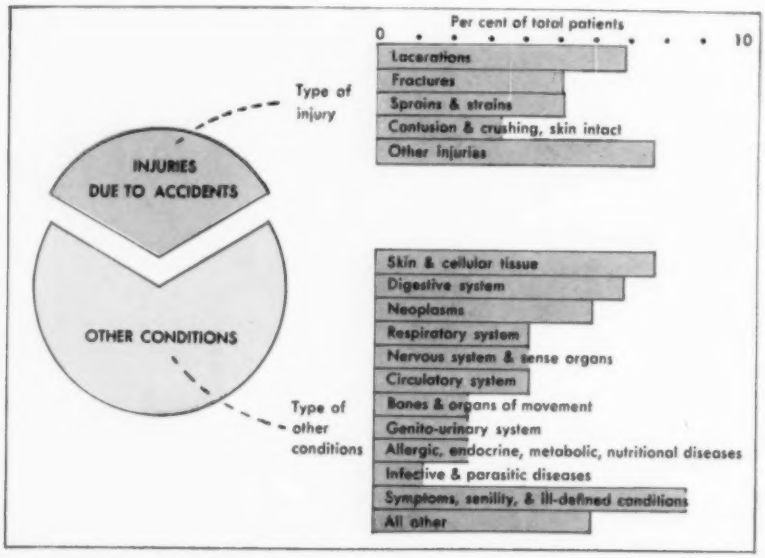


Fig. 4—Although accidents account for the largest single group of conditions treated, they represent only one-third of total.

tions which are judged by house staff from review of the medical record to have required medical attention within 12 hours of onset to prevent possible loss or impairment of life, limb or body function comprise one-half of all the visits. These are represented by the categories "emergency" and "urgent." Of the remainder, 4 per cent could not be judged adequately as to their urgency from the information recorded, and 15 per cent were scheduled procedures, such as minor surgery and endoscopies which are booked in advance. Nearly one-third of the visits then are for conditions which are distinctly of a nonurgent nature. (The patient's definition of the situation may of course be quite different from the physician's; this is itself an area which deserves more intensive study.)

In many hospitals, scheduled procedures are not a responsibility of the emergency unit. The data on urgency might therefore be viewed

EMERGENCY UNIT

after excluding scheduled procedures and also cases of doubtful classification. The remaining cases were distributed as follows:

Total	**100%**
Emergencies	7
Urgent	55
Nonurgent	38

A revealing perspective is provided by comparing the privately treated with house treated patients.

1. Almost one-half of the private patients used the emergency unit in connection with scheduled procedures, whereas only 3 per cent of the house service cases were for this purpose. The private physician thus uses the emergency unit as a specialized resource for his ambulatory patient, preferring to use the hospital's facilities rather than his own office for certain procedures. In the case of clinic patients, many of these procedures are performed in the clinics without involving the emergency unit.

2. House service patients predominate in visits for nonurgent conditions (94 per cent of all nonurgent visits). Among private patient's visits, the nonurgent category constituted 7 per cent; among the house service patients, they accounted for 39 per cent. For the private patient, of course, the doctor's own office is the natural place for the problem that is not urgent. However, the patient who wishes to make use of the hospital's resources directly has the choice of the outpatient department or the emergency unit.

3. A significant aspect of the emergency unit's function in medical care is revealed by the large number of problems treated by private physicians which, although urgent, are less than emergent. Choice of the emergency unit rather than the doctor's private office for these "urgent" conditions (36 per cent of all the private visits) must hinge in large part on the physician's preference – to save time, to have the benefit of the hospital's resources, to accommodate the pa-

IS HELPFUL TO PRIVATE PHYSICIANS

tient's convenience, to allow for possible emergency factors.

Here again, the data may be viewed without cases of scheduled procedures and doubtful classification. The comparative percentage distributions are then as follows:

	Private	House
Total	100	100
Emergencies	6	7
Urgent	79	51
Nonurgent	15	42

Diagnosis. The broad extension of emergency unit problem beyond traumata is demonstrated in Figure 4. Although accidents account for the largest single group of conditions treated, they are outnumbered 2 to 1 by all other conditions combined. The proportion of accident cases in this emergency unit corresponds exactly with the national average of emergency unit experience — one-third of all cases.[9]

Disposition. Figure 5 outlines the disposition of the patients treated in the emergency unit. Three-fifths of the patients are referred for further care to either the outpatient department or a private physician. One-tenth of the patients are admitted to the hospital for inpatient care after examination in the emergency unit.

Of the patients admitted to the hospital, 11 per cent were treated in the emergency unit by private physicians and 89 per cent by house staff. Admissions to ward service came wholly from the cases treated by the house staff. Admissions for private care, however, were made from both groups — most of them, in fact (13 out of 22), from the house service group. This shift from house service to private care may occur with a patient who normally has a private physician for most of his medical care. It may also occur with any patient who has insurance providing hospitalization benefits. Furthermore, a patient whose usual source of care is a clinic may be induced by the anxiety about hospitalization to exercise a choice of physician by going into a private accommodation rather than on a ward.

Of those referred to private physicians, more than one-fourth were treated by house staff in the emergency unit. Only house service patients were referred to O.P.D.

[9]Dickinson, F. G., and Martin, L. W.: Accident Burden on Hospitals, Bull. 104, Bureau of Medical Economic Research, Chicago: American Medical Association, 1957.

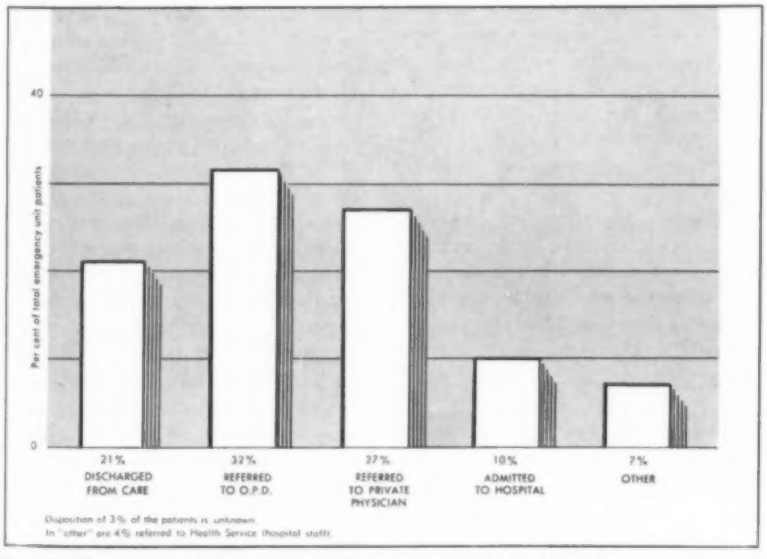


Fig. 5—This chart of disposition of patients treated in the unit shows three-fifths are referred to O.P.D. or private physicians.

Comments

With regard to general methods of obtaining medical care, it is clearly a mixed group which uses the emergency unit. As many patients make *joint* use of the emergency unit and the outpatient department for ambulatory care within the hospital as use the emergency unit alone. The study shows a marked relationship between use or nonuse of the O.P.D. and the patient's choice of being attended in the emergency unit by the house staff or by a private physician. It should be evident that where one group of patients relies heavily on the outpatient department for medical care, and another group is mainly oriented to private physician care, the use of the hospital's emergency unit fits differently into the patient's total structure of care. Not separately identified at all in the present study are those emergency unit patients who are cared for by house staff but whose *usual* source of medical care is a private physician. Each of these patterns has its distinctive implications for the functions of the emergency unit.

It will be important to make a more intensive study of these groups from the perspective developed in this study of outpatients at Beth Israel Hospital — namely, to study the patients' use of the emergency unit in the context of their over-all patterns of obtaining care.[10] The function of the emergency unit may be very different for patients whose visits are outwardly for the same purpose, but whose total patterns of obtaining medical care are different. ■

[10]Solon, J. A.; Sheps, C. G., and Lee, S. S.: Delineating Patterns of Medical Care, Amer. J. of Pub. Health (forthcoming) 1960.

Illinois Supreme Court Ruling

Board Can Amend Hospital By-Laws To Stop Cumulative Voting

SUPPOSE the hospital of your interest is a nonprofit general institution that wants to increase the size of the board and change the voting arrangements for electing it.

Who has this authority—the board or the members of the corporation?

In Illinois, this question was decided by the state supreme court, which recently reversed a lower court decision involving Westlake Hospital, Melrose Park, Ill.

The court* made a distinction between the voting rights of members of nonprofit and for profit corporations. In effect it ruled that a majority of the board rather than a majority of the voting members of the corporation can amend the by-laws of a nonprofit corporation if this is not contrary to the original by-laws.

During the depression of the 1930's, the hospital, a for profit corporation called the Proviso Hospital Association, was reorganized into nonprofit Westlake Hospital Association.

The original by-laws of Westlake Hospital were adopted in 1939. They provided for three classes of members — regular (stockholders from the earlier corporation), life (those who donated funds), and honorary. The board consisted of nine members, elected for three-year terms by all the members.

The by-laws stated that any by-law changes could be adopted "by a majority vote of the members of the board, provided that no such change shall take effect until 30 days after the mailing of notice thereof, with copy of the by-laws as so proposed by the board, to all members of the corporation."

At a board meeting in June 1949, the board of directors was authorized to increase its membership from nine to 11. In the next few years, the board was expanded to 15 by a series of resolutions.

At a board meeting in December 1952, at which were present 11 directors of the 15, including five who were members of the original nine-member board, the by-laws were unanimously amended. Included in these amendments was authorization to increase the number of directors to 15, who were to serve for terms of three years or less. Copies of the amended by-laws were mailed to all members of the association.

The court record shows that in September 1955, a special meeting of the members of the association was called. Among the actions taken at this meeting was a purported by-law change that granted to members of the association the authority formerly granted to the board of directors.

In addition, the by-laws were changed to permit a nine-man board of directors to serve one-year terms.

The board of directors of the hospital, however, met in November 1955 and also amended the by-laws. These changes in effect abolished cumulative voting — an arrangement whereby each association member could conceivably vote several times for one candidate rather than one time for each of several candidates. This made the board self-perpetuating and transferred the right of election from association members to the board.

Shortly thereafter the members — not the board — again met and voted to nullify the amendments passed at the previous meeting of the board of directors. They also voted to reestablish the right of members to elect directors and proceeded to do so.

Thus, in January 1956, two boards of directors of Westlake Hospital were elected, one by the board at its annual meeting, and one by the members at their annual meeting. Two sets of by-laws were also in existence.

Suit was then brought by the group representing the members to determine which board and by-laws were legal.

The superior court of Cook County decided the case in their favor. By its judgment the trial court held that "the board of directors did not have the power to amend the by-laws, and that if the board had such power, its exercise to deprive the members of their right to elect the directors, to vote cumulatively, and to amend the by-laws would violate the 14th amendment to the Constitution. . . ."

The defendants (the board of directors) appealed and the judgment of the trial court was reversed by the state supreme court. In its decision, the state supreme court made the following points:

1. The meeting of the board in December 1952, when the by-laws were amended to provide for 15 directors, was legal since five of the original nine-member board voted at that time for this change.

2. The voting rights of members of nonprofit corporations are not governed by the same state laws that pertain to members of for profit corporations.

"It is well established in this state," the Illinois supreme court noted, "that the right of members of a not-for-profit corporation is not constitutionally protected. . . ."

3. The court noted that the statement under which Westlake Hospital was first incorporated "clearly delegated to the directors the exclusive power to make by-laws, but subjected such by-laws to modification or amendment by the members. . . . If, after amendment of the by-laws by the directors with proper notice thereof to the members, no action was taken by the members at the regular annual meeting, an adjourned session thereof, or a special meeting called for such purpose, altering or modifying the amendment made by the directors, then such amendment would certainly become a valid and existing part of Westlake's by-laws."

4. The court took no position on "the wisdom and desirability of a co-optating or self-perpetuating board of directors for a charitable corporation. . . . We only find that the creation of such board by valid amendment of the by-laws does not deprive plaintiffs of their constitutional rights." ■

*Westlake Hospital Association v. Blix, 148 N.E. 2d 471 (Illinois, 1958).

Although there are differences, a general hospital can conveniently operate a nursing home — with benefits to both

Hospital and Nursing Home Go Well Together

R. C. Barnes

OPERATION of a nursing home in connection with Eliza Coffee Memorial Hospital, a general hospital in Florence, Ala., has proved both practicable and desirable.

When the hospital acquired this annex seven years ago it was intended to relieve an acute bed shortage. We transferred long-term patients and others requiring little skilled care or specialized equipment to make more beds available for the acutely ill. The annex has served its purpose well in this respect. However, it did not take many months of operation to find that we were operating a convalescent and nursing home as distinguished from a progressive care unit. There is a difference.

Because hospital people have the technical knowledge necessary to care for sick, injured or handicapped persons, it is comparatively easy to operate a nursing home in connection with a general hospital. There are certain fundamental differences that must be recognized, and provided for, if the needs of the patient are to be fully met. We do not pretend to know all the differences or all the answers.

In this article I hope to describe the operation of the nursing home in relation to the hospital and describe the essential facts that point out some of the differences in operation.

Location. Our annex is located more than a mile from the hospital. At the time of acquisition, this seemed to be an obstacle that would lend to higher operating costs. If such is the case, it is a minor obstacle that should not cause alarm. In many ways it is preferable that the two operations be separated. This is particularly true in establishing eligibility for admission of borderline cases, and in creating a homelike atmosphere in the nursing home.

Occupancy. Originally 13 beds were available. In less than one year we operated at full capacity. An addition increased this to 23 beds, which is the present capacity. More than 30 patients are on the waiting list. During the last 12 months occupancy was more than 99 per cent. Another addition is now in the planning stage. The need continues to rise. At present we do not plan to expand to more than 50 beds. Our plan then will be for another nursing home. Our present thinking is that the ideal nursing home should not exceed 45 or 50 beds.

Admissions, Records and Charges. Each physician who admits a patient must complete a physical examination at time of admission and must certify that the patient does not have a contagious or communicable disease; that the patient is not addicted to alcohol, drugs or narcotics, or suffering from any nervous or mental disorder that would render him dangerous to himself or to others; that in his opinion the patient can be cared for adequately in the nursing home.

The patients admitted could generally be classed in broad terms as convalescent, chronic, or having diseases of degeneration. More specifically, we have cared for fractured hips, fractured legs, arthritis, rheumatism, senility, multiple sclerosis, diabetics, patients with indwelling catheters, terminal cancer, cardiovascular diseases, and paralysis in many forms.

At the time of admission the patient or his sponsor must sign a financial agreement which sets out in every detail the services to be rendered, the charges for such services, and the method and time of payment. An inventory of personal effects of the patient is made at the time of admission, which clearly sets out the limit of our liability. Arrangements are also made for the patient's spending money and the accounting that will be done by the home. These forms are made in duplicate, one being retained in the patient's file and the other given to the patient or sponsor. A patient register is maintained at the home similar to that used by most hospitals. This register shows the case number, name, address, date of admission, date of discharge, name of relative or friend, diagnosis, and so forth. This register is posted from an admission form prepared for each patient. This is identical with the

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One advantage is that the hospital and home can share services such as purchasing, accounting and laboratory procedures

form used at the general hospital. A copy of this form is furnished to the business office of the hospital.

The same rate is charged all patients regardless of the type of case or the amount of nursing care required. This rate primarily covers room and board only, since special services such as laboratory, x-ray, medicines, drugs and dressings are extra. We do reserve the right to require the family to pay extra or furnish additional help in cases requiring continuous care. We are under the impression that the ambulatory or semi-invalid requires about the same amount of time as the bedfast patient, if not more. Our charge is $42 per week or a day rate equal to that of a private room at the hospital. The day rate was established to discourage the admission of short-term patients or those who should be hospitalized.

Before we admit patients we gain some knowledge of their ability to pay. This is a necessary procedure. We talk quite frankly with the patient or the sponsor about this matter. Many of these patients come to spend the remaining years of their life with us or decide to after they are admitted. Too often they have not given thought to what the continuing expense can be. The signed financial agreement, the preliminary investigation, and the frank talk has eliminated our collection problems.

All accounting is done at the hospital. Bills are rendered from the hospital. Payment can be made to the hospital or at the home. The home keeps bound receipt books which have triplicate copies. The original is given to the payor, the duplicate with the payment is sent to the business office, the triplicate remains in the receipt book and is signed by the cashier of the hospital when the money is turned over to the business office. Departmental revenue and expense accounts are maintained. Indirect and service department expenses are allocated.

Building and Equipment. Eight bedrooms have adjoining restrooms with commode, lavatory and medicine cabinet with mirror. Eight have private restrooms with lavatory and medicine cabinet with mirror in the bedroom. The others have lavatory only. We consider the adjoining restroom preferable. We have found two baths with tub and one with combination tub and shower adequate. Each tub should be equipped with substantial grab bar. We recommend a bar the entire length of the tub, mounted 12 inches above with adequate room between bar and wall for arm or elbow to clear. Pull-up bars should be provided for all commodes. We suggest handrails on all corridor walls. Handrails on both sides of ramps or steps are a must.

The building is completely air conditioned with window units. The furnace room is a separate building approximately 50 feet from the main building. Heating is by gas-fired circulating hot water.

We suggest in planning that at least 25 per cent of the rooms be in one section to house noisy patients and soundproofed to protect other patients.

Consideration should be given to providing one room for a beauty and barber shop. An examining room is essential. Unless all rooms are private or the home is at the hospital, at least one isolation room should be provided for suspect cases. A large sun porch is a must.

A large combination utility, chart and medicine room has proved satisfactory since the amount of activity is less than in a general hospital.

We have found the variable height bed with self-adjusting springs popular. This is especially desirable for ambulatory patients. All types of side rails have been resisted. In almost all cases the night table is preferred to the bedside cabinet. The over-bed table is popular with bedfast patients. The vanity type dresser with mirror serves well as a dresser, writing table, and often as a table at mealtime. A larger clothes closet than provided in a general hospital is desirable. A floor lamp with heavy base, to serve as a reading lamp and equipped with a night light, is used. One easy chair and two straight chairs have been adequate.

Safety. Fire rules and regulations are similar to those of the general hospital. Since the number of employes on duty is considerably less than at the hospital, emphasis with the fire and police department is on evacuation. A plan has been worked out where all available police cars and three fire stations answer the alarm. We get special permission from the commissioner of the fire and police department to turn in a false alarm from time to time. On the last

Nursing home, left, is more than a mile from the hospital — but they still go together.

alarm, in less than three minutes we had four fire trucks and three police cars with a total of 14 men at the home. Twelve drills per year are held for employes. On most of these drills, prearranged with the fire department, the employes are led to believe there is a real fire and follow all procedures, including use of the fire alarm box.

A constant check must be made on all patients' rooms. Long-term patients do a lot of accumulating and can easily create a fire hazard in their rooms. We have found that we must supervise the smoking of a large percentage of our patients. The rule generally followed is that ambulatory patients cannot smoke in bed and bedfast patients' smoking is supervised.

The greatest potential accident hazard is falls that result in broken hips. We try to protect ourselves by insisting that certain patients have an attendant when getting out of or into bed or when moving from one location to another.

Supervision and Personnel. Supervision of the home is by an assistant director of nurses from the hospital with special skill in administrative supervision. The daily time spent at the home varies with the need. A practical nurse is in charge of the home and acts in a limited capacity as superintendent. She coordinates and supervises the various activities of personnel, prepares menus, and makes out supply orders and work schedules subject to the approval of the assistant director of nurses. The assistant director of nurses actually serves as administrator of the annex under the general supervision of the hospital administrator. During the early days of operation considerable supervision was required. Now that personnel is stabilized and routines and procedures have been established a minimum of time is required. In fact, we suspect that over-all supervision required is less than that for a nursing unit in the hospital. Long-term patients and the nature of their diseases are doubtless prime factors responsible for a minimum amount of supervision.

Personnel requirements per patient are a fraction over one-half that of the hospital. Average cost per patient day in salaries is considerably less than half because less skilled help is needed.

Normally the morning shift uses one licensed practical nurse, two students, one nurse's aide, and one male attendant (who is also on call for emergency procedures). The evening shift uses one L.P.N. and one nurse's aide. The night shift uses one L.P.N. and one nurse's aide. The night shift could function with only one person and provide adequate care. The second person is employed only as a safety precaution. The morning shift could operate with one less person if we discontinued the training of practical nurses.

Other employes consist of a cook, assistant cook, kitchen helper, and maid.

Groundskeeping and maintenance are done by the hospital department. A preventive maintenance program has practically eliminated emergency calls.

Medical staff and Nursing Service. Medical staff privileges are more liberal than at the hospital. Other physicians, legally licensed to practice, of good repute, who are too far distant from the hospital to be members of the medical staff, may admit patients and follow through with their treatment and retain their patients, provided they and the family will name a staff physician to act in an emergency. Visits to the patient do not follow any set pattern. This depends upon the condition of the patient, the wishes of the family, and other factors regarding medical care. However we insist upon a recorded physical examination at least annually if the patient is not seen often by the physician and interval notes made on the chart.

Basically, nursing service follows the same pattern as geriatric nursing. In the nursing home less skilled personnel can be utilized because the same procedures are followed over and over for the long-term patient. Daily visits to the home by a registered nurse ensure that all patients are receiving quality care. A supervisory nurse is always on call. More bedside nursing care is required than for the hospital patient. Student practical nurses receive excellent training. Charting is of the short form type. Except for the sickest patients, we would use diary charting of a general nature if we did not have students. Many patients require feeding and encouragement in their eating.

Medicines and Drugs. Patients have the choice of ordering their medicines from their favorite phar-

macy or obtaining them through our pharmacy. Incidentally, none of the patients has ever used any pharmacy other than ours except for the medicines that they bring with them when they are admitted. Medicines and drugs from our pharmacy are sent out under prescription label for each individual patient. The name of the medicine is also labeled on the back of the bottle under cellophane tape which can be removed should the patient be discharged and take the medicine home. Refills from our pharmacy are by prescription number. Markup on this medicine is about half that of regular patients. Most of the medicine used is taken for a long period of time and the price reduction seems in order because of quantity purchase. In addition to the patients' regular medicines, a stock of emergency drugs, such as stimulants, is maintained. There is also a small floor stock of medicines maintained, such as aspirins, laxatives, and so on. All medicines are under rigid accountability controls.

Special Services. Laboratory examinations are done at the annex or specimens are sent to the laboratory. Patients are taken to the hospital for x-ray examinations. Portable x-ray equipment would be desirable even though it could be considered a luxury. Nasal oxygen is available for emergency use.

Purchasing. The quantity buying power of the hospital is used whenever possible. All supplies are requisitioned from the hospital. Direct purchases are made of dairy products and some groceries. A domestic type deep freeze unit has helped solve the problem of quantity purchasing of some items of food.

Dietary. The technical knowledge of the hospital dietitian is used in the general operation of the dietary department of the home. This especially applies to food handling, sanitation, special diets, and so forth. We feel that a separate kitchen is an asset. It is an extremely difficult task to get an elderly person to change his food habits. The noon meal for patients on a regular diet is nearly standard. Breakfast varies with almost all as does dinner. With the smaller operation we can give more individual attention. We use central service and feed all patients in their bedrooms even though some are ambulatory. We find a divided opinion regarding a dining room. In our opinion the dining room creates a problem because of restricted diets and the changing moods and fancies of some of the elderly patients. We do use the dining room from time to time as we invite members of a patient's family to dine with him on special occasions.

We have used a combination of commercial and domestic type kitchen equipment. As replacements are necessary, we will use domestic equipment, wherever possible, except for range and dishwashing equipment.

Our diet pantry consists of domestic type refrigerator and a 500 pound ice maker, cabinet sink, and wall cabinets.

Laundry. Soiled laundry is picked up daily. Fresh laundry is delivered from the hospital once each week. Daily patient requirement is approximately one-third that of a hospital patient. Diapers for incontinent or drainage cases have proved economical and satisfactory. If the patient prefers, we furnish laundered hospital gowns at no cost. Other patient laundry service is not included in our rates.

Recreation and Occupational Therapy. A large recreation room is provided in a quiet area of the home. This room is provided with a piano, radio and record player, television and movie projector. A small library of books and records is available. This library is growing steadily by donations. Patients may have their own television or radio in their bedrooms if they desire.

Evaluation. Nursing homes, like hospitals, have individual atmosphere and personality. Just as the experienced hospital administrator can usually judge the efficiency of a general hospital by the atmosphere, so can the nursing home be judged. The criteria for judging the nursing home in many respects are the same as the hospital. Nursing care, housekeeping, grooming of patients, professional and technical skills in caring for the sick are common to both. An informal atmosphere, the lack of clinical coldness, the individuality of patient rooms, a good recreational and occupational therapy program all contribute to the happiness of patients. These give the nursing home personality and are an excellent criteria for evaluation. ■

Nursing Home Reduces Hospital Costs

IN EVERY respect we have found the operation of a convalescent and nursing home by our hospital to be practicable and desirable. We do not know of any obstacles or disadvantages to a hospital's operating such an institution. Some advantages have been mentioned. There are many more. It releases needed beds for acutely ill patients, but also provides convalescent beds at considerably less cost. Many patients who can afford to pay the full cost in a nursing home can only pay part of the cost in a general hospital. In our state, welfare recipients cannot have their hospital bills paid but can receive a substantial sum for payment to a nursing home.

Problems of the nursing home follow the same general pattern of the hospital but with less scope. Usually nursing home problems are confined to employe-patient relationships. The selection of personnel capable of understanding the normal characteristics of the aged or long-term patient is essential. We have generally found employes who are past 30 years of age to be best suited for this work. We cannot hide the fact that a few problems have arisen during our operation. Our outline of policies and manner of operation make this obvious. ■

A Modern Management Feature

You can be sure that an organization is quick to catalog the friends of the administrator — and even quicker to resent any show of favoritism

Good Judgment Is Impersonal Judgment

Ray E. Brown

GOOD judgment has been called the child of wisdom; doubtless, bad judgment must have other parents. In last month's article an attempt was made to seek out part of the family tree of bad judgment. This search was concerned with several of the tendencies demonstrated by all human beings and which inhibit good judgment. Every person is a battleground of such tendencies, but those who demonstrate good judgment oftenest have learned to control those tendencies best. The tendencies discussed in the preceding article were largely related to the emotional handicaps we often place on our judgment.

Closely related to the emotional blocks to good judgment is the failure to maintain an impersonal status in the organization. The administration needs to protect a sufficient area of aloofness within the organization to permit him to think and act impersonally. Admittedly, he must be responsive and friendly so that others will not hesitate to approach him and will recognize that he has their interests at heart.

Both he and those around him, however, must see the difference between the administrator's liking them, and liking everything they do. The first will temper his judgment and his use of it. The second will seriously compromise both the formulation and exercise of his judgment.

Personal relationships represent one of the most effective sets of mind-cuffs the administrator can wear. The more intimate the relationship, the more serious is its restraint on the exercise of good judgment. On the one hand, it blinds our judgment because we take much more for granted if we have an attachment for an individual. We do not practice the healthy sort of skepticism so necessary in good judgment and in good administrative practice because we tend to equate liking with likelihood. We place confidence in what an individual does and says because we have confidence in his

This is the third and concluding section of Mr. Brown's discussion of judgment in administration. The first two articles appeared in the March and April issues of this magazine. Mr. Brown's series of Modern Management articles will continue in subsequent issues.

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friendship. In a way we are assuming that our closest friends are the smartest persons around the premises. We confuse good intentions with good judgment.

Often a close friendship with the administrator adversely affects the reliability of the counsel that is given him. It is not that close friends mean to be dishonest with each other. It is simply that we do not relish the idea of hurting a friend. We want him to feel good so we tell him things that we think will make him feel that way. This causes us to fail to tell him the things that will keep him from feeling good.

We protect our friends from the truth out of a mistaken notion that it is better that they feel good than that they be good. Our motives at times also go beyond protective custody of the feelings of our friends. No one cares to risk the friendships that he values or which have value for him. Some administrators recognize this fact and at times go outside the organization for advice.

Nothing Shakes Morale So Much As a Sudden Lowering of the Boom Without Prior Warning

One of the few sure things about human nature is the fact that we take things personally. The closer the bonds between individuals, the more likely they are to think that there is something personal in the actions or remarks of the other person. Our resentment seems to be in direct relationship to the extent to which we think something was meant to be personal.

Most married men learn early that they cannot advise or criticize their wives because of the strong personal ties between them. For this reason a man always tells his wife that her new hat is a bargain and that it is very becoming. She insists upon having the husband's opinion but will tolerate it only if it seconds the motion.

At the same time, however, she will accept objectively the comments of the strange sales girl who waited on her at the hat store. Men react just as personally to criticism from their wives. The administrator can afford to gild the relationships he has at home and with his friends outside the organization. He cannot, however, exercise good judgment, or be effective, if he persistently does this at work.

Personal relationships that inhibit detached evaluation and proper criticism represent a disservice to all concerned. Criticism is fundamental to improvement and every member of the organization has a right to expect that he will be told when his performance needs improvement. Nothing shakes the morale of an individual, or the organization, as much as the sudden lowering of the boom on an individual without prior notice to the person to improve his performance. The rules of fair play are applied more strictly to the administrator than to anyone else. These rules require that a person be told where he stands and why. These same rules also require that all members of the organization be treated equally and that close friendships be checked at the door.

The organization closely observes the actions and attitudes of the administrator and is quick to catalog the friends of the administrator. In fact the employes are too quick in many instances in doing so and at times assume that certain individuals have an "in" with the administrator simply because he gave a decision in their favor. Those who lost the decision have a strong tendency to look for hidden motives rather than at the merits of the case. The best of individuals have to resist the temptation to rationalize their setbacks and to feel the deck was stacked.

The easiest explanation to ourselves, and to others, is to blame defeat on favoritism. When close friendship does exist the case is pretty tight against the administrator no matter what the real facts might be.

Imagined or real, few things the administrator can do are as bitterly resented as favoritism. The resentment is not restricted to those directly affected but is shared by those kibitzing from the sidelines. To a large extent the organization will tolerate inconsiderateness and even injustice on the part of the administrator if all members of the organization are treated the same way. The organization adjusts itself to a degree to such treatment and sees nothing personal in it. Any variation in treatment as between different individuals in

the organization, however, is taken as favoritism and it is doubtful that any organization can ever accommodate itself to such double standards in administrative conduct.

Men like to be treated fairly but they demand that they be treated impersonally.

The necessity of fair criticism might seem at variance with the "sweetness and light" doctrine one hears preached so often today. If that doctrine means the administrator has no right, and no obligation, to express irritation over faulty performance it is indeed at variance with proper administrative conduct. Just as the administrator should demonstrate approval for a job well done he must also demonstrate disapproval with inadequate performance. It is the only way the organization can determine the level of performance expected by the administrator.

Whether we mean to or not, we become sponsors to things we permit or tolerate. Most of us find it difficult to separate our idea of good work from the boss's acceptance of it. Normal people will most often do what is expected of them but few will do more than they think is expected. They cannot be expected to live up to their responsibilities unless they know what is expected of them. It is important, however, that the administrator be able to demonstrate disapproval without demonstrating hostility and without creating antagonisms. Only by reserving a margin of impersonal relationship can he hope to be emotionally casual in arriving at good judgment and in exercising it.

This matter of personal relationships brings us to another cause of defective judgment. This is the assumption that people act logically. The evidence indicates that individuals do not usually act logically, or illogically, when they are personally involved. In such instances we are most likely to act nonlogically. This is because we are persons and bring to every situation our own personal experiences, biases, desires and needs. Situations are seen from each individual's own uniquely personal perspective.

As someone has said, no man comes to work alone. He brings with him his church, his family, his friends, and all the many other influences that condition his way of thinking and acting.

This means the administrator always works with used human beings — he never gets a shiny new model to break in. Because of this cultural coercion, individuals, even with the best of good will, honestly see and understand the same things differently. In a given situation we think as we are used to thinking and thus we see each situation in about the same old light. This requires the administrator at times to temper his decisions to allow for the personal equation, and to work toward the modification of the preconditioned notions and attitudes of those who will be affected by his decisions before those decisions are put into effect. It is not enough for the administrator to mean well — his decisions must also look well if they are to be implemented well.

We think about what we want to think about as well as what we are used to thinking about. The interests of people are never identical and the personal stake of each individual must be measured in each situation. The preachment that understanding produces agreement assumes that the individual seeking agreement holds the interest of the other party, or parties, high above his own. It also assumes that where there are two or more other parties involved he can perform the neat acrobatic stunt of holding two interests higher than each other at the same time.

The Administrator Should Not Expect Any Merit Badges From Those Who Are Adversely Affected by His Judgment

Administrators who have faced the problem of deciding among subordinates for a choice promotion recognize that understanding does not homogenize agreement. This does not mean that the administrator should not seek the understanding of those affected by his decisions. To the extent that it demonstrates his desire to act rationally it will help assure acceptance. It does mean, however, that he should not expect any merit badges on behalf of his judgment from those who are adversely affected by his decisions. He should not be surprised when occasionally some of his best laid plans are slipped an oversized mickey by those who are personal losers from those plans.

Our evaluation of the conduct of others is further confused by the idea that all their behavior is purposive. Much of our behavior has no specific meaning.

As administrators we are concerned with the specifics because situations are made up of specifics. The individual, however, has an imperfect awareness of his own motives for most of his specific actions. If he has motives they are probably much more general than specific actions indicate. When conduct really is purposive it may be quite misleading to the observer. The individual is not always able to know what conduct best fits his purpose nor is he always able to achieve the sort of conduct that he knows is best for the purpose.

Our actions often may result less from intent than from inability of the intent to best express itself or to

maintain control. Also, our lives are not confined to single purposes but are made up of many purposes. Even if we have major, dominating purposes our general scheme of conduct is shaped more importantly by the much larger number and greater variety of lesser purposes.

This multipurpose feature of human conduct is confusing to the administrator whose judgment assumes single-purpose and logical behavior on the part of those around him. It will be even more confusing to his judgment if he doesn't keep in mind the fact that he is also a member of the human race and that his own outlook is conditioned.

His reactions have the same tendency to be compatible with his own personal interest. To whatever extent possible, he needs to be cognizant of his own personal biases and to allow for these in his evaluation of situations and the people who are involved in them. The recognition and appreciation of his own biases, and those of his colleagues, will permit him to accommodate to them and counteract some of their influence on his judgment.

It is likely that the administrator will have much stronger biases than other members of the organization on matters that affect the enterprise. The administrator represents the enterprise and must carry its party line. The direction of his thoughts and attitudes is in large part ready-made for him. To an extent his point of view is store-bought by the purposes and program of the enterprise rather than custom-tailored from his personal specifications. Often it is even made up of hand-me-downs of predecessors who set the cut of it when long-term plans and programs were established. The lower the administration position in the hierarchy the more stock-size point of view the administrator must exhibit, but strangely enough, the higher the administrative position the less the freedom he has to make alterations on those stock sizes.

The top administrator must fit his decisions both to the central purpose of the enterprise and to all the members of the organization. Policies that come in standard sizes are much more likely to fit the greatest number of situations because that is what standard means. This means his point of view is biased toward organizational goals rather than toward the goals of individuals within the organization. Because he is so strongly biased organizationally he is likely to assume equal motivation on the part of other members of the organization.

Unless he is to err repeatedly in judgment it is necessary that he always remember that his bias for the total enterprise is usually shared only in proportion to the level in the organization occupied by other members of the organization. In fact it may not even be proportional because a similar sort of bias is developing in favor of departmental and subdepartmental goals all down the line.

Although the Facts Always Speak to Somebody, They Don't Always Say the Same Things to Everybody

The goals of different parts of an organization can never be identical with the goals of the total organization. Neither can the interests and ambitions of administrators of the parts be identical with those of the administrator of the whole. They need not be at cross-purposes but the difference in responsibilities preclude the chance of their being identical purposes.

Strong and aggressive departmental administrators must be expected to work vigorously toward the best possible performance by their own department. The sales manager cannot be expected to view the work of his salesmen through the eyes of the credit manager. The production manager should be expected to resist some of the thinking of the industrial relations manager. The chief administrator must of necessity see things a little differently than any of his subordinates if he is going to see in common with each of them.

From our individual point of view we usually make sense to ourselves. If one understands us a great deal of our behavior is predictable. This understanding permits others to take into account our eccentricities. Such understanding, however, is in itself proof that more is needed in dealing with others than one's own system of logic. When we say we make allowances for the reactions of another person, we are really saying that we cannot expect him to react as we think he ought to react, or as we think we would react.

Making allowances for the different outlook of another person does not mean making allowances for his job conduct. Sometimes we may have to do the latter but it represents a default in our responsibility to the enterprise, and perhaps to the individual. We must make allowances for his difference in outlook in order better to perceive the difficulties which confront us in attempting to influence his behavior, and to permit us to modify his outlook. The recognition of the non-logical nature of human behavior is a way of improving our judgment and not an excuse for poor performance.

Somewhat related to the assumption that people, including the administrator, always act logically is the assumption that the facts speak for themselves. It is true that facts always speak to somebody but they don't always say the same things to everybody. The same facts say different things to different people. This means

the administrator cannot always take things at their face value. The actions of an individual may mean any one of several things. The credit manager who, after being criticized because of a general increase in the total of accounts receivable, sends a nasty collection letter denying a discount to the firm's best customer who has always paid promptly on the fifteenth of the month, rather than on the first as specified in the discount terms, may have done so for any one of several reasons.

He may have been wanting (1) to get even with his superiors, or (2) to prove his point, or (3) to make a good impression by improving the collections, or (4) simply to follow what he thought was a new policy. It may even have been done without his knowledge and he accepts the blame to avoid offending one of his subordinates or out of fear that the subordinate would be discharged. It could also have been due to a combination of two or more unrelated purposes or entirely without purpose.

Even if it were done maliciously it may indicate nothing of his true attitudes and such a demonstration may never be repeated. The same individual may have strong loyalties to the organization and simultaneously have strong feelings about the way it treats him.

The Desire To Live Up To Our Reputation Is a Strong Force

All human beings seem to be capable of a great deal of ambivalence in their feelings and within the same personality there is at times an active interplay of conflicting feelings. Such strong tendencies to do and not do the same thing are demonstrated by the fact that we have "mixed feelings" about certain problems we face. This fact has not been too well recognized by those who have written our texts on motivation. They have stressed our specific motives rather than our system of motives. Perhaps it is more a confusion of motives than a system. It may be that we seldom do things for a single reason but instead for a number of reasons. At least the administrator is taking a gamble if he accepts at full value the apparent reason and lets it do all the speaking for a given situation.

The tendency to listen to the facts instead of examining them is more than a problem of naivete to the administrator. It prevents the sort of double-talk that seems to go along with healthy relationships.

> ***People often do things and say things they do not mean because the situation dictates that they do so. Group pressures of this sort on individuals are well documented. The pressures within the individual are perhaps even more important. Each of us has an image of ourselves that we feel we must maintain. We act tough because we feel we have a reputation for toughness.***

One of the strongest forces felt by an individual is the desire to live up to his reputation. He may have gained the reputation fortuitously but it is his trademark and he is stuck with it. For this reason many of our acts do not mean what they seem. The place that an individual occupies also influences his actions. All of us are constantly defining and redefining the role we feel we are playing. We attempt to act as we think someone in our role is supposed to act. For instance, we yield to our superiors because we believe our role in the organization demands that we act that way.

This fact explains the amazing metamorphosis that seems to occur when individuals previously considered timid are promoted and instantly exhibit aggressive leadership abilities. Those who evaluate individuals only by how they act, and disregard the context in which they are acting, are making the same error in judgment as do those who buy a book because of its cover rather than its contents. When we insist on the literal meaning of the actions of others we prevent them from saying and doing things, harmless to the organization, which relieve their feelings. We give full value to action taken at time of emotional stress and attempt to make the individuals involved eat their words or to confess their error.

The same facts say different things to the same person at different times. We know the same individual reacts quite differently to similar situations at different times. Each of us reads into a situation much of what our mood tells us to read at a given time and usually we can see a good bit of what we want to see in it. We appear to have a wonderful faculty for ignoring incidents on one occasion and ballooning their significance on another. To the administrator a complaining customer may be someone who needs help on one day and a person who wants to be nasty on another day.

The facts may not change but we do. Or, at least, we change our spectacles and succeed in distorting our view of the facts. We also seem to be able to develop quickly a psychological deafness to facts that disagree with our expressed opinions or that are inconsistent with our preconceptions. At the same time we seem to have an automatic range-finder for the facts that speak for our side or which keep us from having to change our mind.

The tendency to assume that the facts speak for themselves can lead to a *res ipsa loquitur* sort of administration — to steal a term from the lawyers — in which the organizational acoustics are designed to magnify the noise rather than screen it. Good judgment is impossible without good facts on which to base one's judgment. Good

facts, however, are in themselves a product of good judgment.

The administrator must let his judgment determine which facts are relevant and what weight to give their voice. Facts are good only if good use is made of them. The way they are used depends upon the administrator's judgment and in turn they determine the quality of his judgment in a particular situation.

Taking the facts at face value helps accentuate another strong inhibition to good judgment. This is the high degree of inference-proneness with which administrators are afflicted. Jumping to conclusions is an occupational hazard of the administrator because he is destined to make most of his decisions from incomplete and obscure data. Most administrative problems are problems only because the full facts are not known and often are not available. The administrator is compelled to spend much of his time reading between the lines and in extrapolating from his experience and from his knowledge of the environment in which he is working. His skill in inference drawing is a highly valuable asset if it is used properly.

The sort of mind developed by experience in administration also makes the administrator more susceptible to inference drawing. The trained mind in any profession is filled by preconceptions. These preconceptions consist in part of professionally inspired attitudes. To a large measure individuals in the same profession see things in the same light. We say a person acts like an accountant or a lawyer, or a minister. This means they will infer certain things from situations that confront them. Each, according to his training, will overlook certain of the details that are present and supply certain other details that are not present. Because the administrator works under the heaviest sort of time and load pressure, he is forced to overlook most of the details and to supply a great deal more than is present.

Unless the Administrator Listens Carefully to Others, He Will, in Effect, Just Be Listening to Himself

The most important set of skills used in administration are the conceptual skills. These are the skills that permit an administrator to put two and two together without being told what the second two are.

> ***The best administrators are those best able to supply the missing links in a situation. The nature of his job forces the administrator to take many things for granted and consequently eliminate them from consideration.***

The habit of inference making can seriously affect the administrator's judgment. Unknowing, he may read into situations what he wants to find in them. Or he may read into situations a large portion of what he expected to find in them. Under these circumstances we don't have to jump to conclusions — we start at the finish line. We are inclined to ask the sort of questions that are most likely to yield the sort of facts that support our own notions. We turn to those individuals for information and advice who are most likely to see the particular problem as we do, and who are, therefore, most likely to voice our own opinions.

Unless conscious effort is made by the administrator against overly projecting his own outlook into every situation, he may develop a sort of "echo" administration in which he assumes the strange posture of leaning on himself for facts and advice. His colleagues are not always certain to provide sufficient protection from this hazard. Everyone likes to give answers that are used and appreciated. This means we usually think in terms of advice and answers that we think will be acceptable to the asker.

The sort of mental shorthand that goes along with inference drawing may cause the administrator to cut emotional corners by evaluating the personalities involved rather than the problem. Individuals are easily stereotyped and their image of the individual can easily overshadow the available facts surrounding a problem. Because we tend to agree with those we like, and disagree with those we dislike, there is a strong temptation to short-cut our judgment and read our answers from our emotional notebook. Too often important decisions are made on the basis of who says what. This practice can at times represent a double fault. Our likes and dislikes may develop from single incidents that totally misrepresent the true nature or intent of the individual concerned, but we mistakenly keep on making situations congruent with our misconceptions of the individuals involved.

> ***The imperfections inherent in the mechanics of talking and listening encourage administration by inferences.***

We can think about six or seven times as fast as we can talk. This means the listener has a great amount of spare thinking time while the other person is talking.

This spare time is a delightful invitation for inference making. It permits the listener to anticipate what the speaker is going to say and never really hear what the speaker actually said; to add in ideas of his own and thus put words in the speaker's mouth; or to let his mind wander in and out and thus lose the full context of what was said.

Any of these effects means that the chances for proper inferences have been greatly decreased. It also means that unless the administrator carefully listens to others he will in effect be listening to himself. This might be a very interesting monologue to the administrator but it doesn't yield much to him in the way of facts about a situation. He cannot expect to think usefully about a situation unless he has some idea as to what the situation is. ■

How Regulation Differs From Accreditation

Regulatory agencies differ in basic function from voluntary standard-setting organizations — and these differences are important to an understanding of how and why legislation is used to regulate

Gertrude Binder

VOLUNTARY standard-setting organizations and regulatory agencies both have as an objective improvement of the general level of practice in the field with which they are concerned. Nevertheless, their basic functions are different.

Legal regulation moves toward the common objective by establishing minimum requirements applicable to all facilities and raising these minimums as rapidly as public acceptance permits. Voluntary agencies are free to ignore substandard operations and concentrate on the development of institutions which set an example of superior service. There is a significant difference also in that the voluntary agency is accountable to its membership or to the profession it represents, but the regulatory agency is accountable to all people of the locality which enacted the law it administers.

These are a few of the reasons the activities of voluntary organizations and regulatory agencies cannot be equated, and why their standards are not interchangeable.

Every state in the union provides by law for some form of regulation of medical care facilities, although the types of facilities covered vary from state to state. The U. S. Department of Health, Education and Welfare has issued "A Directory of State Agencies and Program Directors Responsible for the Licensure of Hospitals, Nursing Homes and Homes for the Aged," as of June 1, 1959. It shows that hospitals are licensed in every state and territory except Delaware, Louisiana, Texas and the Virgin Islands. The compilers of this directory evidently used the word licensure broadly to denote all forms of legal regulation, but legal regulation does not always take the form of licensing. In New York, for instance, the Social Welfare Law gives the Board of Social Welfare broad and diversified powers to regulate the conditions under which institutions, both nonprofit and proprietary, may come into being, to establish rules setting the conditions under which they may operate, and to enforce such rules. However, licenses from the department are required for only a small group of dispensaries.

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Basic Features of Regulation

While supervision of the kind the New York State Board of Social Welfare exercises over medical care institutions is not the exact equivalent of licensing, its basic features are the same.

Legal regulation, whatever its form, must be carried on within limits defined by the law; the agency responsible for administering the law must establish rules and it must enforce its rules. It should also, through education and supervision, endeavor to raise the level of practice and public understanding of what constitutes good standards of service in the regulated field. In some states, provisions of regulatory statutes include that the administrative agency shall give consultation service, advice and educational direction to the agencies and facilities under its jurisdiction.

Because governmental agencies have an educational as well as regulatory function, a question often arises as to how their activities differ from those of voluntary organizations such as the Joint Commission on Accreditation of Hospitals. Such voluntary accrediting agencies set criteria of practice and attempt to promote systematic self-regulation by the profession or industry concerned. Like official agencies charged with administering regulatory laws, they must develop standards, and these standards usually include educational guides to good practice. They are similar to regulatory standards also in that both have "mandatory" minimum requirements. There is a basic difference, however. In governmental regulation "mandatory" means that facilities which do not meet minimum requirements may not, legally, continue in operation. Requirements of voluntary agencies have no such legal status. The only penalty for noncompliance with them is exclusion from accreditation or from membership in the standard-setting organization.

A second question almost invariably comes up when a state or local agency begins to write or revise its regulatory standards. It is: Why can't the governmental agency simply adopt and apply the standards which

voluntary organizations have already painstakingly and responsibly developed? A review of the basic features and purposes of legal regulation may help to explain how it differs from voluntary standard setting and why a governmental agency cannot fulfill its responsibilities by simply adopting the standards developed by voluntary organizations.

Protection of Public

The primary purpose of legal regulation is the protection of users of a service or type of facility against risks which they could not protect themselves against without governmental assistance. Raising the level of practice is a by-product of such protection. The number and degree of risks that can be eliminated increases as the level of practice rises, but the basic purpose of regulation remains the same: to assure all who must use a service that certain minimum standards of safety and good practice are observed.

Regulatory standards and requirements must apply to all facilities not specifically excepted and to the entire geographical area covered by the law. The law or the rules of the administrative agency should contain clear definitions. Hospital regulation, for instance, cannot be effectively carried out without a definition of the word "hospital." Every facility coming within the definition and not specifically excepted, must be held to the regulatory requirements. This differs from voluntary accreditation which can be applied only to institutions that desire it.

Legal regulation must be concerned with all aspects of operation that affect the safety and well-being of persons served. Among the matters for which the law usually requires the agency that regulates medical care facilities to establish rules are buildings, sanitation, staffing and standards of care. In other words, sanitation, building, safety and housekeeping practices, as well as quality of professional service, must be regulated in order to ensure the safety of the users of the service.

If the administrative agency does not itself promulgate rules regarding all of these matters it must coordinate the work of other related agencies and determine that necessary safeguards exist. For instance, in a state which has a fire marshal with statewide authority his duties in regard to hospitals are probably separate from those of the regulatory agency. However, it is the responsibility of the regulatory agency to ensure that the operator of the hospital protects patients from the danger of fire by getting the necessary inspections and clearances from the fire marshal. In a state which does not have a statewide fire protection law calling for the inspection and approval of buildings by a fire authority, the regulatory agency is obliged to establish its own rules to assure minimum safety against the dangers of fire. A voluntary agency can select the matters with which it will deal.

Legal regulation is authoritative. If it is well administered, it is educational in its effect and results in upgrading standards of practice. Nevertheless, its basic function is protection of the public, and in order to carry out this function the administrative agency must be prepared to enforce its minimum requirements. It must, if necessary, force the closing of facilities which cannot or will not comply with the standards established by the agency.

Rules Must Be Practical

Because the rules of an administrative agency have the force and effect of law they must be practical and realistic. Otherwise they become dead letters. Enforceability involves many considerations other than desirable practice. Where there is a shortage of hospital beds, lower standards may have to be accepted or people will not be cared for at all. Availability of trained staff for certain kinds of services, availability of funds to pay for them, and public acceptance of the necessity for certain requirements, as well as identification of professionally sound practices, are among the considerations that must go into the development of good standards for legal regulation.

Because they have the authority of law, regulatory rules must take into account the constitutional rights of those who operate the regulated facilities as well as those who use them. They must apply equally to all who are affected. If, for instance, both proprietary and nonprofit facilities are subject to regulation, applicable requirements should be the same for both. The interests of those organized into trade or professional associations, including voluntary accrediting bodies, may not be placed above the interests of those who choose not to join such associations.

The standards of governmental agencies must be nonpartisan. They may not give preference to factions or to proponents of particular ideas. A voluntary organization may in its accreditation program favor a particular school of thought or method of practice that does not have general acceptance. It may also decide not to grant approval to facilities operated by dissident professional groups whose activities are legal, though not

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What Causes Regulatory Legislation

Regulatory legislation usually comes into being when a social problem has become too complicated and too widespread to be dealt with by individuals, unassisted by their governments. The operation of a hospital, for instance, involves many highly technical and specialized procedures. It would be unreasonable to assume that each of the hundreds of thousands of users of hospitals should be competent to evaluate for himself the standards under which the hospital renders service and decide whether they are safe. Some may argue that regulation is a limitation on personal freedom in that it prevents an individual from seeking care in any kind of facility he chooses, regardless of how it is operated. Most, however, expect government to provide a degree of protection against hazards they are in no position to guard themselves against.

ABOUT PEOPLE

Administrators

Alvin J. Conway has been appointed executive director of Knickerbocker Hospital, New York, where for the last three years he served as assistant administrator. Prior to his appointment at Knickerbocker Hospital, Mr. Conway was administrative assistant at Roosevelt Hospital, New York. He received his master's degree in hospital administration from Columbia University School of Public Health and served his administrative residency at Lebanon Hospital, New York. Knickerbocker Hospital also announced the appointment of **Joseph F. Ladislaw** as controller. Mr. Ladislaw previously held the same post at Staten Island Hospital, Staten Island, N.Y.

James E. Smits has assumed his new post as Southern California regional hospital administrator for the Kaiser Foundation Hospitals. For the last 10 years, Mr. Smits has been administrator of Children's Hospital, Los Angeles, and previously was with the Los Angeles County hospital system as assistant director of General Hospital and director of Harbor Hospital. Mr. Smits is a trustee and president-elect of the California Hospital Association and a past president of the Hospital Council of Southern California. He is a member of the governor's study committee on health needs.

J. E. Smits

Raymond A. Baldwin has been appointed administrator of Beaver Valley General Hospital, New Brighton, Pa., succeeding **Theodore F. Kapp Jr.**, whose resignation and appointment to the Hospital Council of Western Pennsylvania was announced in the March issue of The Modern Hospital. Mr. Baldwin was formerly administrator of Beebe Hospital, Lewes, Del., and administrative assistant at Memorial Hospital, Cumberland, Md. He is a graduate of the University of Pennsylvania, Wharton School of Business Administration.

Robert R. Martin, assistant director of Rex Hospital, Raleigh, N. C., since 1956, has resigned to become assistant director of James Walker Memorial Hospital in Wilmington, N. C. Mr. Martin, a graduate of Wake Forest College, completed his training in hospital administration at Rex Hospital in 1954. From 1955 to 1956, he served the North Carolina Medical Care Commission as assistant hospital administrator. **J. Crenshaw Thompson,** administrative assistant at Rex Hospital since 1957, succeeds Mr. Martin as assistant director. Mr. Thompson attended the postgraduate program in hospital administration at the Medical College of Virginia.

J. C. Thompson

R. R. Martin

Bernard Fuss has been appointed associate director of Sinai Hospital, Detroit. Mr. Fuss was formerly assistant director of Beth Israel Hospital, New York. He received a master's degree in psychiatric nursing from Adelphi College and a master of science degree in hospital administration from Columbia University School of Public Health and Administrative Medicine. Mr. Fuss is a nominee of the American College of Hospital Administrators.

Greer Williams has been named assistant director of development of Children's Hospital Medical Center, Boston, where he will be in charge of a 10 year planning and development program associated with Children's Hospital's 100th Anniversary to be celebrated in 1969. For the last four years, Mr. Williams, a medical science writer, has been director of information for the Joint Commission on Mental Illness and Health and for the preceding four years, he was director of public relations for the American College of Surgeons. Mr. Williams is a contributor to the *Saturday Evening Post* and author of "Virus Hunters" published by Knopf's in 1959.

G. Williams

Bright M. Dormblaster has been appointed director of Franklin County Public Hospital, Greenfield, Mass. Mr. Dormblaster received his master's degree in hospital administration from the University of Minnesota and served his administrative residency at Mary Fletcher Hospital, Burlington, Vt. He has been assistant administrator of Danbury Hospital, Danbury, Conn., and is a member of the American College of Hospital Administrators. Mr. Dormblaster succeeds **Alexander McAliley.**

Dr. Sidney S. Goldstein has succeeded **Dr. John F. Regan** as superintendent of State Hospital for Mental Diseases, Howard, R.I. Dr. Goldstein formerly was director of the neuropsychiatric department at Charles V. Chapin Hospital, Providence, R.I. In addition to his M.D. degree, Dr. Goldstein holds a degree in pharmacy from the former College of Pharmacy and Allied Sciences in Providence. He is a member of the staffs of Rhode Island and Miriam Hospitals and Butler Health Center, Providence, and is a consultant to the Rhode Island Division of Mental Hygiene Service at O'Rourke Children's Center.

John H. Beddow, former administrative vice president and general manager of Middlesex General Hospital, New Brunswick, N.J., has been named executive director of Jewish Chronic Disease Hospital, Brooklyn, N.Y. Mr. Beddow was formerly administrator of Brevard Hospital, Melbourne, Fla., and director of West Hudson Hospital, Kearny, N.J. He is a member of the American College of Hospital Administrators and the board of trustees of the New Jersey Hospital Association.

J. H. Beddow

Sister M. Felicitas, R.N., S.F.P., has been named administrator of St.

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Why Nurses Leave—and What To Do About It

Although hospitals can't control all the factors that cause nurses to quit their jobs, they may reduce turnover by improving salary scales, making working conditions more attractive, and reducing pressure on nurses

Joan S. Dodge, Ph.D.

IT SOMETIMES appears to hospital administrators that the struggle to reduce nursing turnover is a lost cause – and they have some reason for this view.

Research on the reasons nurses leave their jobs indicates that:

1. Large hospitals have higher turnover rates than small ones.

2. Type of sponsorship influences the rate.

3. Hospitals with schools of nursing have relatively more turnover than hospitals without such schools.

4. The turnover rate is higher for young nurses than for older ones and higher for staff nurses than for supervisory personnel.

5. Work load, pay scales, necessity for night work, interpersonal relations, and so forth are not especially important factors. Personal reasons outside the hospital's control account for the majority of nursing turnover.

What do these findings mean to the hospital administrator? Taken all together don't they seem to indicate that there is nothing much he can do to reduce turnover at his hospital? He cannot, after all, cut a wing off his hospital to reduce its size. Nor, if he has a school of nursing attached to his hospital, can he shut it down in the interests of solving his immediate problem. Similarly, as nurses have to be younger before they can be older, he's got to hire them young or risk having no staff whatsoever in a few years. Thus, his hands would appear to be tied.

The findings on job satisfaction serve to reinforce this notion. If dissatisfaction with hospital conditions is not strongly related to decisions to leave or stay, then why attempt to change the conditions at all? The heavy incidence of personal reasons unconnected with hospital characteristics implies that this would not reduce turnover. Thus, research findings suggest that the situation is rather hopeless.

However, it is not quite as hopeless as it might appear. Although some nursing turnover is doubtless unavoidable, it is helpful to examine some of the factors behind the reasons given for leaving. In this study we attempted to distinguish between avoidable and unavoidable turnover before exploring the factors related to a hospital's turnover rate.

It was felt that hospitals having approximately equal total turnover rates might differ in terms of how much of this turnover was caused by pregnancies, illness and so forth, and how much was more voluntary. Differences in hospital and nurse characteristics associated with the latter kind of turnover might be of use to the administrator. By doing something about these factors he could conceivably affect the turnover rate at his hospital.

Six hospitals took part in this study. All were voluntary general hospitals ranging in size from 112 to 450 beds. These hospitals provided information about each full-time professional nurse who had been in their employ during any period of the previous year (1957). It included such things as the date the nurse was hired, termination date, if any, and the reason given for her leaving. It also included certain background characteristics such as her age, training school, position, salary and so forth.

From the data on the nurses' employment histories, turnover rates for each hospital were computed by dividing the total number of terminations during a year by the average number in employment during that year. To find the "average number in employment," the number of full-time registered nurses on the payroll on the first day of the year was added to the number on the last day. This sum was then divided by two. The reasons given for leaving were scrutinized to determine the percentage of this turnover that was voluntary.

For turnover to be classed as voluntary the nurse had to be able to make a conscious decision to leave the hospital or continue working in it. The alternative she chose had to be under her own control and, conceivably, the hospital could influence her decision by meeting any objections or making it more attractive for her to remain.

Involuntary turnover, on the other hand, is relatively unavoidable. There is hardly any decision to be made because there is virtually only one alternative. Turnover due to pregnancies,

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husbands being transferred to other communities, physical ailments that make it impossible to continue working, or reaching retirement age fall into this category. It is improbable that the hospital can have any control over the factors affecting it; nor, in any true sense, can the nurse. Once the situation has occurred, her only practical alternative is to leave.

It should be noted that the form on which these data were recorded included the following questions regarding the reason given for leaving:

"How certain are you that this was the real reason?

– 1. Completely certain.

– 2. Quite sure, but some doubts.

– 3. Pretty sure it was not the real reason.

– 4. Completely certain it was not the real reason.

– 5. Don't really know.

If 2, 3 or 4, do you have any idea of what the real reason was?"

Occasionally the responses to these questions indicated that a case that would normally have been classed as involuntary did not rightfully belong in that category. In one case, for example, a nurse had given marriage and moving to another community as the cause of her termination of employment. The nursing administrator knew, however, that the nurse still lived in that town and, what's more, that she had gone to work in a nearby hospital.

Cases considered to be clear instances of voluntary turnover included the following: nurses who transferred to another hospital where hours, pay or type of duty were more satisfactory to them; those who left to work in physicians' offices or industrial firms; nurses who joined the armed forces; those who moved out of town for reasons other than being with husband or family (*e.g.* at one hospital a group of the unmarried nurses had simply packed up and gone to Florida), and, of course, those who openly expressed some type of dissatisfaction as the reason for their leaving.

Not all of the reasons given were as clear instances of voluntary turnover as those listed. In some cases the questions regarding certainty of the truth of the reason helped us make a decision. In others we had to go back for more information. This was particularly true in the case of a category of reasons labeled "family responsibilities." The fact that a nurse has three or four children to care for may, on the face of it, strongly suggest that leaving her job was not a matter of choice. However, the fact remains that there are other nurses with the same number of children who continue to work full-time or part-time year after year. This suggests that nurses who wish to can make some arrangements for the care of their families and remain working. All cases in this category were carefully examined before we classified them as voluntary or involuntary.

The same difficulties were present when a nurse gave marriage as her reason for leaving. Some cases were clearly unavoidable, as when her husband lived and worked in another community. Other cases were clearly voluntary, as when the nurse simply stopped work after marriage, apparently because she no longer wanted or needed to work.

Table 1 shows the total turnover rates for the six hospitals involved in the study, and the percentage of the turnover in each case that was classed as voluntary turnover. As can be seen, the total turnover rates ranged from a low of 26.47 at one hospital to a high of 52.13 at another. Similarly, the voluntary percentages ranged from 29.09 to 50. This latter fact is more interesting to the present study, as it suggests that perhaps there is much that hospitals can do to reduce their turnover problems. The average per cent of voluntary turnover in the six hospitals was 40, and in one hospital perhaps as much as half of the turnover was unnecessary. This does not look as if the situation is quite as hopeless as is often assumed.

The most interesting aspect of this phase of the study lies in the relations between total turnover and voluntary percentages. Although there is a substantial negative relation between the two, it is far from perfect. For example, Hospitals 2 and 3 have high total turnover rates in relation to the rest of the sample, yet they differ considerably in their voluntary percentages. Hospital 2 has a much higher percentage of voluntary turnover than does Hospital 3. It is second highest while Hospital 3, which

Table 1 — Total Turnover Rates and Voluntary Percentages: The Six Hospitals Are Listed in Ascending Order of Total Turnover

Hospital Number	Total Turnover		Per Cent Which Was Voluntary	
	Rate	Rank	Per Cent	Rank
1	26.47	1	44.43	4
5	29.15	2	50	6
4	36.73	3	42.86	3
6	42.67	4	31.24	2
2	46.05	5	45.71	5
3	52.13	6	29.09	1

Table 2 — Reduction in Turnover Possible at the Six Hospitals When Voluntary Turnover Is Controlled

Hospital	Total Turnover	Total Turnover Minus Voluntary Turnover	Saving
1	26.47	14.70	11.77
2	46.05	25	21.05
3	52.13	36.97	15.16
4	36.73	24.49	12.24
5	29.15	14.57	14.58
6	42.67	29.34	13.33

Table 1 shows the total turnover rates for the six hospitals in the study and the percentage in each case that was classed as voluntary. Table 2 shows the saving in turnover for each hospital if voluntary turnover is eliminated.

has the highest total turnover rate, is characterized by having the lowest voluntary percentage. In other words, although Hospital 3's turnover rate is high, personal reasons outside the hospital's control account for most of it. However, even here, 29 per cent of the turnover was classed as voluntary.

Let's think a little further about the situation at Hospital 3. Would it be of value to this hospital to know the factors related to voluntary turnover. Regardless of the fact that the majority of its turnover was unavoidable, would it be important to be able to reduce the total turnover by 29 per cent? It would seem so, as the total rate would drop from 52 to 36, resulting in a substantial saving in personnel expense. As Table 2 shows, similar savings would occur at the other hospitals. Thus, by attending to the factors related to voluntary turnover, the hospitals could possibly reduce their total turnover to more manageable proportions.

A large number of hospital factors could be related to voluntary turnover. These range from the exceedingly nebulous, such as the hospital's philosophy regarding its various spheres of activity, to the relatively concrete, such as size, nurse-patient ratio, and so forth. Obviously it would be impossible to cover all these things adequately in one piece of research. The present research concentrated on the concrete factors, measuring only those amenable to statistical summarization. On the basis of previous research in the area as well as *a priori* hypotheses as to what might be significant, hospitals were compared on the following characteristics: (1) size, (2) age, (3) attractiveness of working conditions, (4) quality of care, (5) pressure on the nurses, and (6) salary scales.

Each of these was defined by one or more objective measures. For example, hospital *size* was measured by the number of beds as well as the average daily census. One measure of *age* was the year in which the hospital was established. Another, that also gave a measure of the *attractiveness* of the working conditions, was the age of the greater part of the physical plant. Transportation to and from the hospital were also considered here. A thorough examination of hospital *quality* was beyond the scope of this research. The autopsy rate, number of facilities offered, and approval by national accrediting agencies were the measures used to make at least a superficial comparison. *Pressure* on the nurses was inferred from the full-time professional nurse-patient ratio, the total staff-patient ratio, the average daily occupancy rate, and average length of stay.

The six hospitals were divided into two groups on the basis of their total turnover rates. Those having the three lowest percentages were classified as "lows"; those with the three highest as "highs." Their mean scores on each measure, as well as their variances, were examined to see which factors were related to the total turnover. These data appear in Table 3. The same data, classified in terms of high and low voluntary percentages appear in Table 4. The tables do not contain data on all the characteristics examined because certain of them did not lend themselves to this type of presentation. These, which include measures of attractiveness of working conditions and salary scales, are discussed separately.

Care must be taken in interpreting the data in Tables 3 and 4. In the first place the sample of hospitals was very small and localized. Such a sample can by no means be considered representative of American hospitals in general. A larger study along these lines is clearly needed before the findings of this study can be considered to have much validity. A second limitation imposed by the size of the sample is the fact that statistical tests of the significance of the differences of the high and low groups could not be carried out. As a result, one must be extremely conservative concerning any relationships between these characteristics and turnover.

Total Turnover. As Table 3 indicates, hospital quality is the only factor clearly related to total turnover in this study. Measures included the hospitals' autopsy rates, facilities offered, and accrediting approvals received. The data suggest that high quality hospitals are more likely to have high turnover rates than are low

Table 3 — Total Nurse Turnover: Scores for Hospitals Having High and Low Total Turnover Rates

Hospital	1	5	4	2	6	3	Mean for Lows	Mean for Highs
Total turnover per cent	26.47	29.15	36.73	46.05	42.67	52.13	30.78	46.95
Year of establishment	1891	1912	1888	1878	1921	1885	1894	1895
Pressure								
Daily occ. rate	0.78	0.78	0.67	0.80	0.72	0.71	0.74	0.74
Nurse patient ratio	3.06	2.83	1.93	2.10	2.16	2.30	2.61	2.19
Total staff patient ratio	1.90	1.81	2.35	1.89	2.36	2.39	2.03	2.21
Average length of stay	6.50	9.50	6.80	7.20	9.40	7.10	7.60	7.90
Quality								
Facilities	15	18	17	20	19	21	16.70	20
Approvals	4	7	8	6	8	8	6.30	7.30
Autopsy rate	0.15	0.41	0.43	0.31	0.67	0.59	0.33	0.52
Size								
Number of beds	134	450	213	199	112	340	265.70	217
Average daily census	104	350	142	160	81	243	198.70	161.30

In the table above the six hospitals are divided on the basis of their total turnover rates, and the group mean scores examined to see which factors were related to turnover. Quality was the only factor clearly related.

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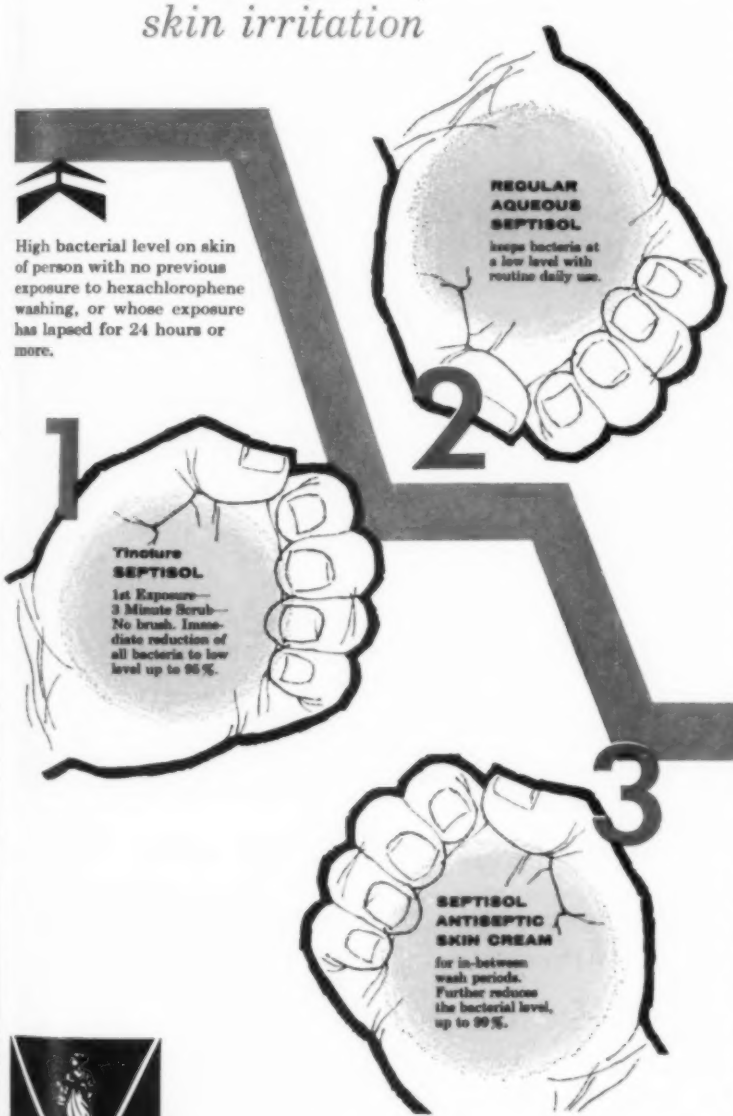

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quality hospitals. This was particularly true with respect to number of facilities offered. In every case, hospitals classified as high turnover hospitals offered more facilities than did those classified as low turnover hospitals.

The point that hospital quality is often related to hospital size might be raised here. Previous studies have shown that large hospitals have higher turnover rates than smaller ones do. In addition, they generally offer more facilities, have received more approvals, and perform more autopsies. However, neither of these things obtained in the sample used in the present study. In the first place, we found no significant relation between hospital size and quality. In addition, as Table 3 demonstrates, hospital size was not related to total turnover, whether measured by number of beds or by average daily census. Although the means revealed that the larger hospitals tend to have lower total turnover rates than the smaller ones, the variability among the individual scores indicated that this was only a chance finding.

An examination of the remaining data in Table 3 indicates no other clear relationships. Neither the age of the hospital, in terms of the year in which it was established, nor the amount of pressure put on the nurses was associated with differential turnover rates. It was felt that hospital age might be relevant either because of the traditions associated with age, or the condition of the physical plant. Findings here were very uncertain, however. Although original buildings varied in age, most of the hospitals were engaged in building programs designed to correct their inadequacies.

As was true in the series of studies by Levine and Wright,* no relation between *pressure* and total turnover was found. **As Table 3 shows, there was no difference in the daily occupancy rates of hospitals with high and low total turnover rates.** Nor are the findings clear in the cases of full-time nurse and total staff-patient ratios. Although both pairs of means suggest, somewhat curiously, that hospitals with high total turnover rates are better staffed, differences relating to total staff-patient ratio are extremely small and the variability within classifications is high. Differences are clearer in the case of the full-time nurse-patient ratio, but even here the hospital with the lowest and that with the highest ratio are in the low total turnover group, making the findings difficult to interpret. Similarly, the variability in the length of patient stay scores minimizes the strength of the relationships suggested by the group averages.

Consequently, differences in pressure relating to total turnover rates appear to be chance differences and are thus in agreement with the findings of Levine and Wright. The rest of the measures presented similar pictures and are not reported in tabular form. All the hospitals presented had some sort of transportation problem. Parking facilities never seemed adequate nor, in general, did public transportation. All the hospitals were about equally distant from other hospitals to which dissatisfied nurses could transfer. All of the hospitals paid lower salaries than were paid for other jobs requiring equivalent education. Other studies have shown the age of nurses to be relevant, with young nurses having higher turnover rates than older ones. The hospitals in this sample, however, did not differ significantly in the percentage of older and younger nurses employed. Except for Hospital 1, where the nurses were on the average somewhat older than those at the other hospitals, the mean ages were similar.

Voluntary Turnover. The data in Table 4 indicate that two major areas are clearly related to voluntary turnover, *i e.* pressure on nurses and hospital quality. The measures of pressure included: (1) the full-time nurse-patient ratio; (2) the total staff-patient ratio; (3) the daily occupancy rate, and (4) the average length of patient stay. All these factors can influence

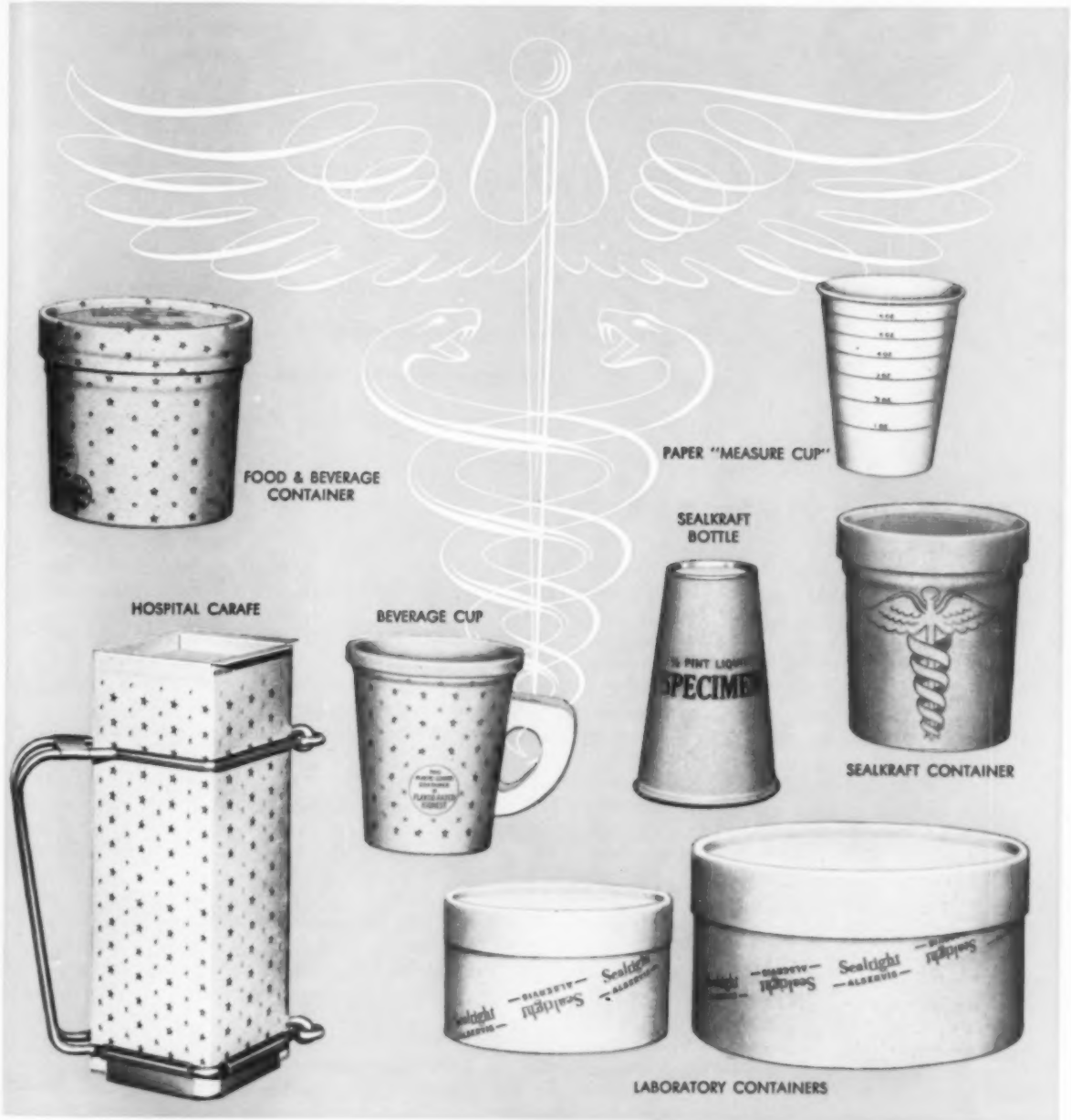
(*Continued on Page* 170)

*Wright, S.: Turnover and Job Satisfaction: Analyzing Turnover Among Hospital Personnel, Part 3. *Hospitals*, (October 1) 1957.

Table 4 — Voluntary Turnover: Scores for Hospitals Having High and Low Percentages

Hospital	3	6	4	1	2	5	Mean for Lows	Mean for Highs
Voluntary turnover per cent	29.09	31.24	42.86	44.43	45.71	50	34.40	46.71
Year of establishment	1885	1921	1888	1891	1878	1912	1898	1894
Pressure								
Daily occ. rate	0.71	0.72	0.67	0.78	0.80	0.78	0.70	0.79
Nurse patient ratio	0.43	0.46	0.51	0.32	0.47	0.35	0.47	0.38
Total staff patient ratio	2.39	2.36	2.35	1.90	1.89	1.81	2.37	1.87
Average length of stay	7.10	9.40	6.80	6.50	7.20	9.50	7.80	7.70
Quality								
Facilities	21	19	17	15	20	18	19.0	17.7
Approvals	8	8	8	4	6	7	8.0	5.7
Autopsy rate	0.59	0.67	0.43	0.15	0.31	0.41	0.56	0.29
Size								
Number of beds	340	112	213	134	199	450	221.70	261
Average daily census	243	81	142	104	160	350	155.30	204.70

The same data as in Table 3 were also classified in terms of high and low rates of voluntary turnover. As table shows, the areas of pressure on nurses and hospital quality are most clearly related to voluntary turnover.



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MEDICINE AND PHARMACY

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How Break-Even Pricing of Drugs Works

This system of drug pricing, which provides a basis for true cost accounting and establishes fair prices for prescriptions, works almost as well in practice as in theory, the authors report

George P. Provost and William M. Heller, Ph.D.

BREAK-EVEN-POINT pricing provides a basis for true cost accounting, and at the same time makes it possible to determine a fair price for prescriptions.

That, at least, is how this system works in theory — and, as we have found out, how it works in practice.

The wide variation found in drug prices in hospitals and the current widespread criticism of drug prices require the establishment of a sound, defensible pricing system based on the hospital's total actual costs rather than an arbitrary system determined in some other manner.

This method of pricing has been used for more than two years in the outpatient pharmacy and for eight months in the inpatient pharmacy and central sterile supply department of University Hospital, University of Arkansas Medical Center, Little Rock.

The use of this system in the outpatient pharmacy has the most widespread effects. During this time we have filled an average of 200 outpatient prescriptions daily. Two per cent of these have been refills. One per cent has been for full pay patients, 15 per cent for patients with some degree of medical indigency, and 84 per cent for totally medically indigent patients.

In addition to the fact that most of our patients are medically indigent, certain other aspects of our operation should be noted because of their possible influence on the use of this pricing system.

Only pharmacists are employed in the outpatient pharmacy. All prescriptions are priced by the pharmacist who receives the prescription and any discussion of the price is carried on with the pharmacist, not with a lay person. Payment is received or arrangements for payment are made before the prescription is accepted for filling.

Approximately 50 per cent of the outpatient prescriptions are prepackaged and lack only the prescription label. This is possible because our medical staff, through its pharmacy and therapeutics committee, tells us which drugs to keep in stock. It then becomes only a matter of experience to determine the quantities most often prescribed and to have them prepackaged.

Again, because of this close relationship with the medical staff, we are able to anticipate prescriptions that would ordinarily require compounding so we actually compound only 2 per cent of our prescriptions at the time they are received.

To adapt the break-even-point pricing system to this operation, we determine our costs as follows:

1. Our proportionate cost of clinic administrative expenses. This was determined by comparing the budget for the outpatient pharmacy against the total budget for the clinics.

2. Our proportion of the cost of physical plant and housekeeping service. To arrive at these costs, we determined the square feet of floor space needed for our total outpatient pharmacy operation, including storage, and multiplied it by the cost per square foot for each of these departments to service the entire building.

3. The cost of pharmacy equipment and fixtures and their depreciation. Fixtures are being depreciated over a 10 year period. Depreciation of equipment depends on the nature of the item. Supplies other than goods sold are also included in this category.

4. A service cost that we have broken into two parts: fixed professional labor, and professional overhead.

Fixed professional labor varies little from prescription to prescription and represents the direct labor cost involved in dispensing prepackaged medication. In addition to the labor cost for filling containers on a mass basis, it consists of receiving the prescription, interpreting it, pricing it, typing the label for it, putting the label on the container, and dispensing it with the necessary oral directions, elaborations and precautions.

But what about the cost of keeping the dispensing pharmacist on duty

George P. Provost was an instructor in the School of Pharmacy and a pharmacist for the University Hospital, University of Arkansas Medical Center, Little Rock, at the time this article was prepared. He is presently secretary of the American Hospital Formulary Service. William M. Heller is assistant professor in the School of Pharmacy and chief pharmacist of the hospital.

Adapted from a paper presented to the section on pharmaceutical economics, American Pharmaceutical Association annual meeting, Cincinnati, 1959.

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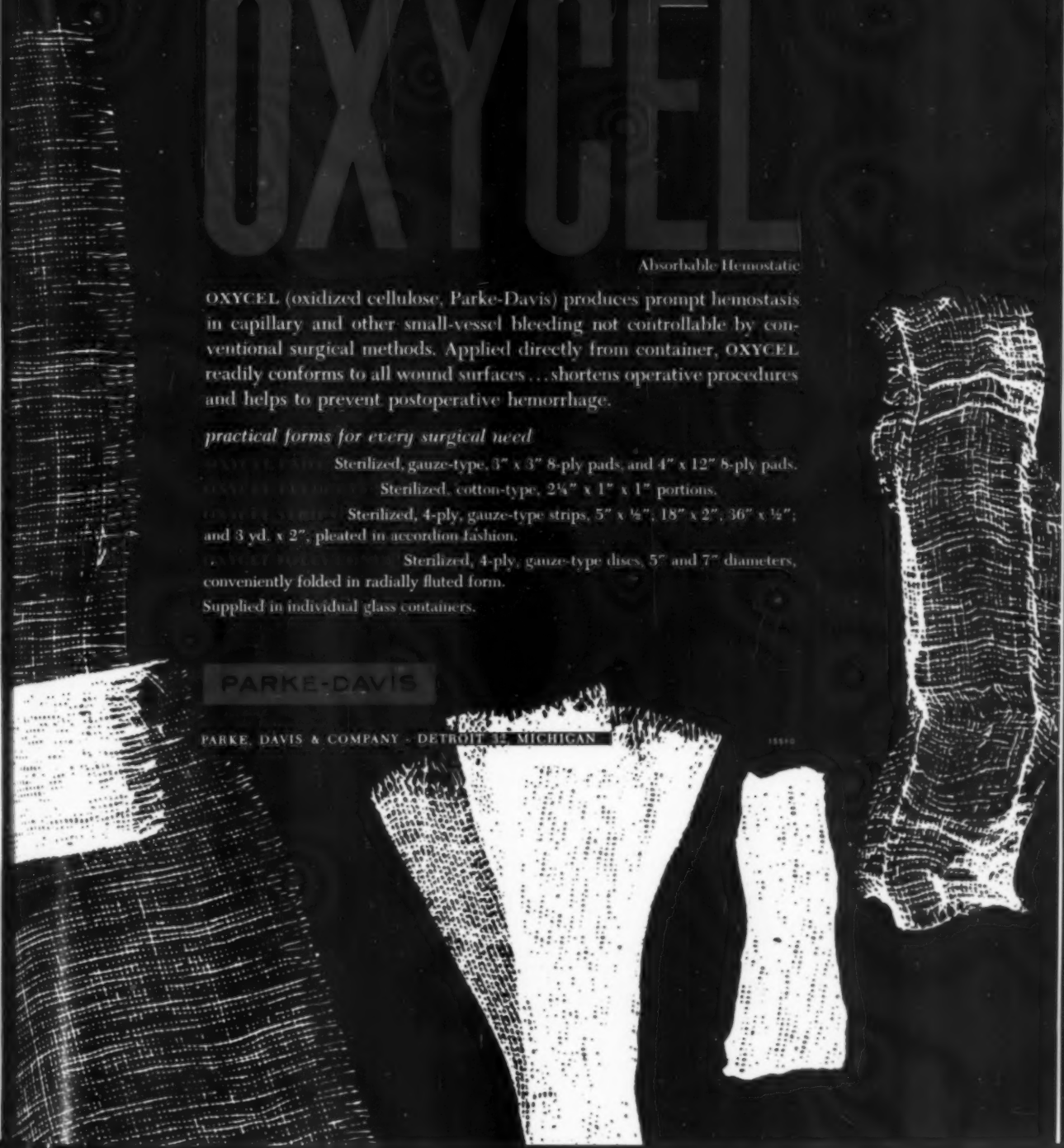

when there are no prescriptions to be filled? How about the labor cost to receive the medication, inspect it, test it, store it, periodically reinspect it? The labor costs to plow through the paper work involved in purchasing it and paying for it? The cost of labor to talk and write to manufacturers and their representatives to find the best product at the best price? The time involved in continually working with the medical and nursing staffs to ensure not only that the best drugs are available, but that they are used most advantageously in therapy?

These are real costs but are not directly related to the purchase price of the prescription medication or to the time spent in filling a prescription; rather, they can be assigned equitably only on the basis of the number of prescriptions filled, since each prescription receives this protection and service of the pharmacist. These are a part of the total overhead costs, "professional overhead." These costs are recalculated annually as pharmacists' salaries increase.

All of these costs — administration, physical plant and housekeeping, supplies and depreciation of equipment and fixtures, fixed professional labor, and professional overhead — are the same for each prescription. We can group them together and call them the total overhead cost per prepackaged prescription. All that remains is the cost of dispensed materials, any cost of labor over and above that required to prepackage the prescription, and the profit.

Cost of dispensed materials consists of cost of container and cost of the drug. Rather than split nickels, we consider the cost of all containers to be the same, except for gallon bottles, large ointment tubes, and plastic bottles. Thus, excluding profit, the only variable factor in dispensing a prepackaged prescription is the cost of the drug itself. The only variable factors in dispensing a prescription not prepackaged are the cost of the drug and the additional cost of labor over and above that which would have been required to prepackage the preparation.

How To Figure Profit

The profit may be added in either of two ways: (1) a fixed fee per prescription or (2) a certain percentage of the total costs of dispensing the prescription. We have used the latter. Four different percentages have been established based on the relative ability of the patient to pay.

In the inpatient pharmacy and in the central sterile supply, items charged to patients are of two types: (1) charge floor stock and (2) nonfloor stock. Costs for charge floor stock items and for nonfloor stock orders are determined in the same manner as for outpatient prescriptions. Personnel and floor space are apportioned to each activity; the subdepartmental budgets are compared to the hospital budget. Table 1 illustrates the synthesis of the selling price for three drugs handled in different ways (the figures used are fictional).

Any drug pricing system worthy of the name must ensure the same price for the same order time after time, no matter which pharmacist prices it. This system does that. Now, what are the special advantages of this system?

From the standpoint of the dispensing pharmacist, the foremost advantage is the ease and speed with which the system can be used. Except for the cost of the drug, all of the cost factors are quickly memorized: the constant total overhead cost, the extra cost per minute for nonprepackaged prescriptions, and the percentage profit. Cost prices per 100 capsules and tablets, per ounce of ointments, and other convenient quantities are listed for each drug on a visible index file. However, even

How Prices Are Synthesized for Three Methods of Dispensing

	Outpatient Pharmacy Prescription: 100 tablets phenobarbital, 15 mg., prepackaged	Inpatient Pharmacy Nonfloor Stock Order: 16 capsules tetracycline hydrochloride, 250 mg., not prepackaged	Inpatient Pharmacy Charge Floor Stock Item: 1 bottle dextrose injection 5%, 1 liter
Indirect overhead costs (hospital or clinic administration)	33.1¢	14.8¢	6.5¢
Supplies and depreciation of equipment and fixtures	0.2	3.3	2.6
Physical plant dept.	1.4	1.4	0.8
Housekeeping dept.	0.1	0.1	0.1
Laundry	0.1	0.1	—
Fixed professional labor and professional overhead	28.1	26.3	12.0
Container	5.0	5.0	—
TOTAL OVERHEAD IF PREPACKAGED (rounded off)	70¢	50¢	20¢
Cost of drug	10	480	70
Extra direct labor (5¢ per minute)	—	18	—
BREAK-EVEN POINT	80¢	545¢	90¢
Profit, 10%	10	55	10
SELLING PRICE (rounded off to nearest nickel)	90¢	$6	$1

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the cost of the drug is quickly learned, as there is no duplication of brands and the brand on hand is usually on an annual contract at a definite price. So that a patient is not penalized by having a particularly slow pharmacist fill his prescription, the average time for filling various nonprepackaged prescriptions has been charted. After a month in the outpatient pharmacy, for example, the pharmacist prices nine out of 10 prescriptions without recourse to a pencil or to any reference.

From the standpoint of the administrative pharmacist, the foremost advantage of the break-even-point system is that it provides a basis for true cost accounting. Since most of the cost factors are constant, it is easy to determine in retrospect the cost of drugs dispensed on any one prescription. Because of this, for instance, we were able to show that, during a certain period of time, welfare outpatients not only received twice as many prescriptions per visit as other patients, but that the cost of drugs per welfare prescription was 40 per cent more than for prescriptions in any other category of outpatients.

The establishment of a budget is simplified because, estimating the number of prescriptions, nonfloor stock orders, and charge floor stock items which will be dispensed, the desired income can be obtained by regulating the percentage of profit.

From the standpoint of the teaching pharmacist, the chief advantage of this system is that the pharmacy student learns to recognize and to consider all of the factors which make up the cost of dispensing drugs. And, by separating the professional costs from the commodity costs, the professional service of the pharmacist is shown in its true perspective to students and members of the other health professions.

What of our public and professional relations as a result of the adoption of this system? We realize that our patients are not typical citizens, economically. Although we made no announcement to the public when we changed over, we received very few comments. The price of most prescriptions changed, some went up considerably and others decreased greatly, but we established a profit structure which would provide the same income we had under our previous system.

Comments from our medical staff have varied and interest in drug costs seems to run in cycles. It is our strong impression that the physicians have shown a greater interest in the economics of prescribing because they know any savings is passed on to the patient. They are more inclined to save money for the patient than to save or make money for the institution. In general, they have applauded the reduction in the price of high-cost drugs and have deplored the increase in price of low-cost drugs, especially when dispensed in small amounts. Over-the-counter drugs are especially troublesome. Those drugs dispensed with the manufacturer's original label intact, e.g. insulin, are now sold at the usual retail price in the outpatient pharmacy.

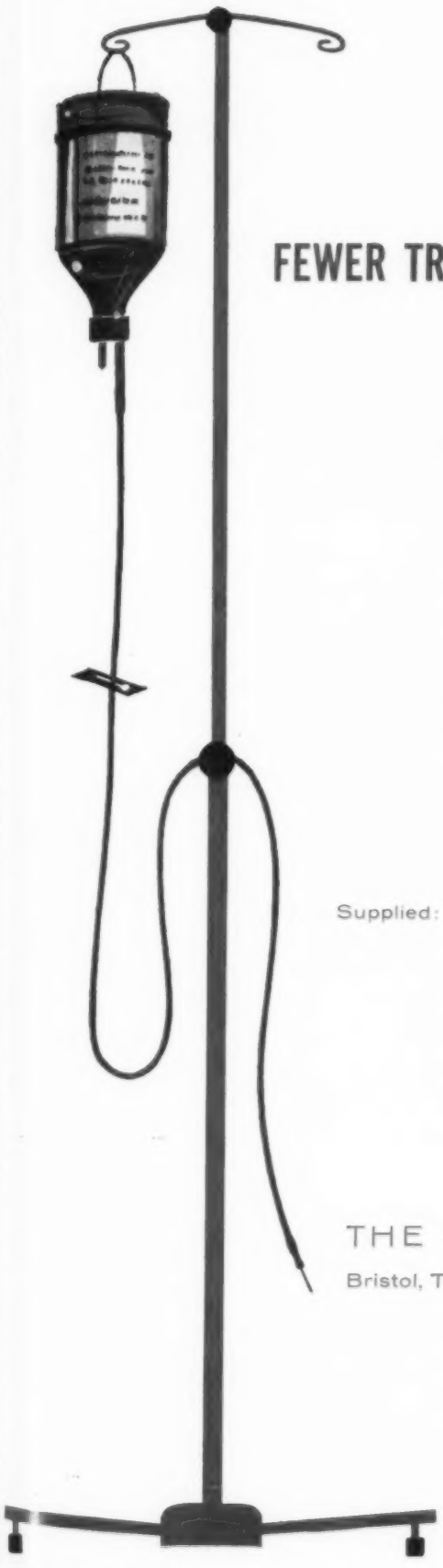
Some Object to System

It has been difficult for some physicians to accept the fact that costs other than the cost of the drug are involved and that those costs can be accurately determined. Some would prefer that these other costs be apportioned according to the cost of the drug rather than according to the number of prescriptions or orders filled, thus lowering the price for low-cost drugs; and others would prefer that our prices reflect those of other pharmacies rather than our own particular costs.

Some community pharmacists, too, have resented the system simply because it is different. On the other hand, other pharmacists have been pleased that we adopted the system. Since our prices now have no relation to the usual prices in community pharmacies, our indigent patients cannot simply multiply our price by a factor to arrive at what they might consider the proper full price for the prescription.

We may summarize the advantages of the break-even-point pricing system as follows: (1) fast, accurate and easy to use; (2) provides a basis for true cost accounting; (3) profit can readily be regulated to provide the desired income; (4) teaches students and members of the other health professions to recognize the various costs involved in a prescription operation.

The disadvantage is that some – but certainly not all – community pharmacists and some members of the medical staff are disturbed because our prices have no relation to current prices in other pharmacies.



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1. 1958 Report of American Red Cross Joint Blood Council
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Ferdinand Haase Jr., M.D.

USE of private patients in a teaching program not only relieves the shortage of service patients, but provides an added challenge for students. Furthermore, we have found at Albany Hospital, Albany, N.Y., there are intangible, but direct, benefits for the patients.

Many years ago the medical board adopted as a general policy the rule that all private patients admitted to the hospital should be available for the teaching program for medical students and the house staff.

For more than 15 years medical students have been assigned to the private patients on all services. They take admission histories, perform admission physical examinations, follow the patients, and write follow-up notes. At times the medical students even write orders for patients, although these orders are not carried out until after they have been signed by a physician. This provides excellent learning experience.

Naturally, during the same period the interns, assistant residents, and residents have participated actively in the care of private patients. **The patient's private physician retains the ultimate responsibility and authority for the care of his patient, but he works with and through the members of the house staff.**

Regard System as Normal

The private patients accept this as a normal situation, probably because everyone, private physicians, house staff doctors, students and nurses, regards it as the normal way of doing things in a large teaching hospital such as Albany Hospital.

Staff physicians encourage rapport between the members of the house staff and their patients – in effect the house doctor is the "associate" of the staff physician in the care of his private patients. The members of the house staff plan for accurate workups for the patients, arrange for proper consultations, and personally supervise the care of the patients. **By virtue of the inclusion of private patients in the teaching program, the house staff members are able to become familiar with the problems of patients with varied social and economic backgrounds similar to those they will later meet in private practice.**

The doctor whose clinical experiences are limited to the care of service patients may develop an impersonal attitude toward his patients, thinking of them as a case of this or a case of that. On the other hand, participating in the care of private patients is more of a challenge to the doctor's ability to handle patients as individuals with a right to demand attention and satisfaction. Furthermore, this gives him an opportunity to observe the technic used by the different private doctors in dealing with their patients. Thus over and above the disease entities encountered, there is an important advantage gained by including private patients in the teaching program.

Private patients are presented at various grand rounds and teaching clinics held in classrooms as well as in the auditorium.

A special feature of our program is the expectant parents open house, which is held once a month at the hospital. The object is to help the expectant parents to understand the physiological progress of childbirth and to introduce them to the hospital routines and atmosphere in such a

Dr. Ferdinand Haase Jr. is medical director of Albany Hospital, Albany, N.Y., and an instructor in hospital administration and pediatrics at Albany Medical College. Previously he had been executive director of Nathan Littauer Hospital, Gloversville, N.Y., and assistant director of Massachusetts General Hospital, Boston. Dr. Haase received his medical degree from Harvard and served his internship and assistant residency at Children's Hospital, Boston. He is a member of the A.C.H.A.

way that they will not feel so nervous and insecure when the mother is in the hospital. This open house consists of:

1. A "down to earth" talk by the resident in obstetrics.
2. Projected slides and a movie.
3. A tour of the hospital.
4. A question and answer period.
5. Light refreshments.

Explains Role of House Staff

The resident not only gives them a better understanding of the physiology of pregnancy, childbirth and the postnatal period, but he orients the patients to the fact that the house staff (including medical students) will examine and assist in their care at all times. He points out that the members of the house staff play a vital role in the delivery and during their entire stay in the hospital.

The parents who participate in this are private patients. It is an excellent experience for the resident and is extremely popular with the parents.

The increasing number of doctors in private practice who participate in one form or another of joint practice with other doctors is introducing more and more patients to the idea of "group care" and undoubtedly plays a part in the patient's ready acceptance of the house doctor.

From the patient's point of view, the only problem we have encountered is an occasional comment that there are "too many examinations." Usually this comes from a female patient and refers to pelvic examinations, but it never has caused a serious problem in public relations. We feel sure that these complaints we have had would not have arisen if the patient had been informed in advance of what was going to be done. For example:

1. An attending obstetrician, assuming there would be no objection, demonstrated to a group of student nurses the technics of a delivery on a private patient who was not under a general anesthetic. Even in this case there might not have been an objection if the baby had been normal. However, the baby was Mongoloid and subsequently the patient tried to blame it on the fact that the doctor was allegedly paying more attention to his class of nurses than to the delivery.

2. An assistant resident took several student nurses into the room of a private patient when he did a routine pelvic examination and he demonstrated the procedure to them. The patient objected that this was an invasion of her privacy. Had the physician taken a moment to explain to the patient, in advance, what he was going to do, we feel sure there would have been no objection.

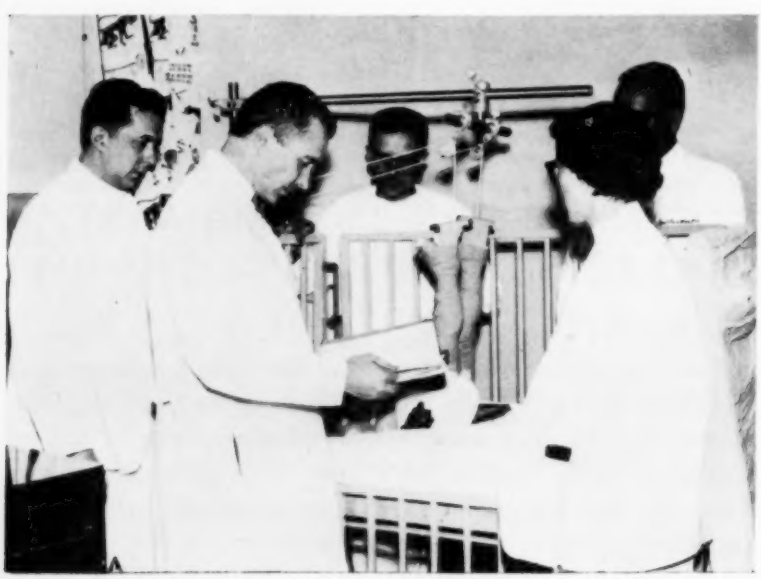
There is no real problem in giving responsibility to the house staff in medicine, pediatrics, psychiatry and the medical specialties. The big problem in using private patients for teaching is encountered in surgery and the surgical specialties at the house staff level, not at the medical student level. This problem is ameliorated to some extent by encouraging the attending surgeon to let the resident who assists him do as much of the operation as possible. In some cases the patient may even consent to allow the resident to be the operating surgeon, while the attending surgeon acts as his first assistant. However, most doctors feel an ethical obligation to the patient to perform the operation themselves. Consequently, here in Albany, we are faced with the same situation which exists nationwide with regard to surgery and the surgical specialties.

Residents Get Surgical Patients

A partial solution to the problem in surgical training created by the decreasing percentage of service patients has been inaugurated at Albany Hospital and at some other teaching hospitals. This consists of encouraging and making arrangements for the attending surgeons to turn over to the resident staff, with the consent of the patient, those patients who have only some modest medical-surgical insurance coverage and who probably would have been self-pay service patients if it were not for the insurance coverage. Most of these patients are perfectly willing to accept the resident as their doctor, and the attending surgeon does not lose much financially because the fee in these cases is small. The resident then turns this fee over to a "house staff fund" which is used for the benefit of all the house staff for such things as attending meetings, subscribing to journals, and other teaching aids.

The use of private patients in the teaching program has proved to have many advantages both for the patient and the student.

For the medical students and the house staff the private patients provide a wealth of experience that could not otherwise be gained in the limited time available. The reputa-



The chief pediatrician reviews a private case with the house staff as part of the training program using private patients at Albany Hospital, Albany, N.Y.

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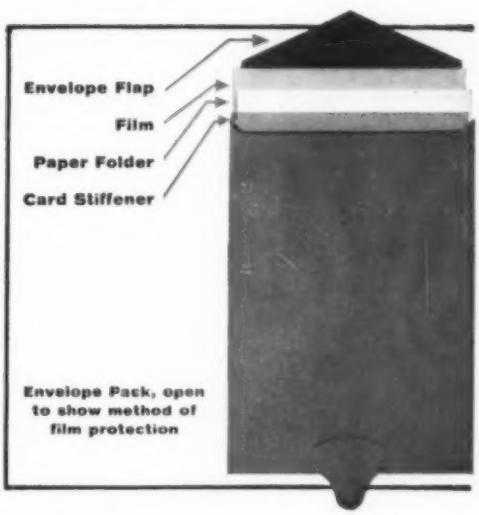

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tion of the hospital and the doctors on its staff results in a great many patients with complicated diagnostic or therapeutic problems being referred to the hospital from a large geographical area. This makes it possible for the students, at all levels, to participate in the care of a disproportionately larger percentage of complicated, difficult cases than could ever be possible by restricting their assignments to service cases only.

Certainly no one will argue against the desirability, from the educational point of view, of students participating in the care of as many combined abdominal-perineal resections as appendectomies, or as many cases of blood dyscrasia as cases of respiratory infection. For all practical purposes this situation exists at Albany Hospital, but it would not be true if private patients were not available for teaching purposes.

Patients Reap Benefits

For the private patients themselves the advantages of this teaching program may not be immediately obvious. Nevertheless, the advantages are there, *i.e.* in academic circles it is well recognized that the students keep the teachers stimulated and on their toes. In a teaching hospital the presence of students (again at all levels) keeps the attending doctors continuously alert to the most recent advances in medical care. Private doctors do not like to be embarrassed by missing a diagnosis a student correctly makes, or by being criticized by the student for not giving the patient the best care.

Not long ago a private female patient was admitted to the hospital with gallbladder disease. This patient was examined by a fourth year medical student who found and described a lump in the breast which had not been noticed by the patient's private doctor or by the resident. This turned out to be an early carcinoma of the breast amenable to surgery.

The constant presence in the hospital day and night of one or more doctors familiar with each patient's condition and needs is made possible by our teaching program. Many patients realize this advantage and are grateful for it.

We are sure we would never want to go back to the system of not completely integrating care of private patients into our teaching program. ■

Modern Hospital Practice

'T&A' Not 'Minor' Operation Medically or Statistically

By Robert S. Myers, M.D.

ALTHOUGH the relative frequency of tonsillectomy and adenoidectomy has decreased by more than half during the last 30 years,[1] it is still one of the most frequent operations performed in general hospitals and accounts for a substantial percentage of all hospital discharges. It is also an operation not free from complications and risk.

Dr. Myers

These conclusions are drawn from a recent report[2] of a survey of 9240 tonsillectomies and adenoidectomies done during 1958 in 24 typical community hospitals, all of which are accredited and 12 of which have approved programs of training for interns or surgical residents.

The report reveals that "T&A" accounted for one out of every 16 discharges, exclusive of deliveries and newborns, in the 24 hospitals participating in this audit. This figure projected nationally means that there are more than one million such discharges (and "T&A's") annually in the United States. This estimate, which agrees with other reported studies, indicates that "T&A's" comprise about 10 per cent of the operations done each year in this country. At a hypothetical average cost to the patient of $50 for hospitalization per "T&A," this would bring $50 million annually to hospitals.

Since "T&A" is quite commonly regarded in this country as a so-called minor operation, it is of interest to review some of the statistics about the physicians who perform it, the complications which occur, and the mortality rate. In the commission's 24 participating medical audit hospitals, E.N.T. specialists performed 48 per cent of the 9240 "T&A's"; general practitioners did 41 per cent, and general surgeons did 11 per cent.

Postoperative hemorrhage occurred in 296 of the 9240 "T&A's" for a percentage of 3.2 or a ratio of 32 per thousand "T&A's." These hemorrhages were not "minor": 52 per cent required tamponage; 27 per cent of the patients had to be returned to the operating room; and 11 per cent required blood transfusions. If this experience is projected for one million "T&A's," it would mean that there would be approximately 32,000 postoperative hemorrhages after "T&A" annually in the United States.

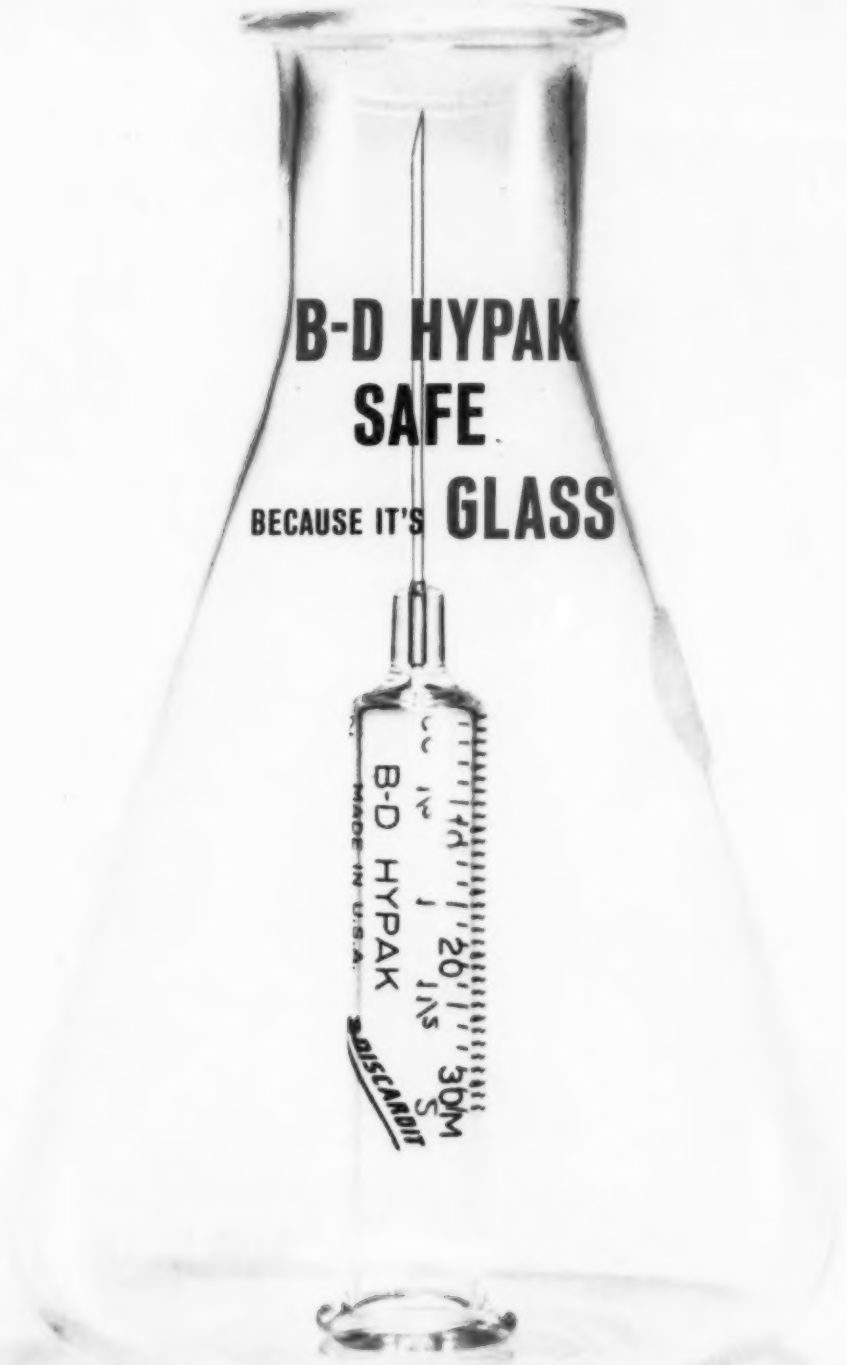
Postoperative hemorrhage rates by classification of operating surgeon are of interest: The E.N.T. specialist had a rate of 25 hemorrhages per thousand operations; the general surgeon, 28 per thousand, and the general practitioner, 42 per thousand.

Three deaths occurred in this series. One was a 31 year old male with cardiac arrest; the second was a 49 year old male who had pneumonia; the third, a 74 year old female who had diabetes and asthma and whose cause of death was not known.

These data confirm impressions we have long held: "T&A" is still a breadwinner for hospitals and by no means a "minor" operation. ■

[1]Progress in Health Services, Health Information Foundation, Vol. 8, No. 8 (October) 1959.

[2]Tonsillectomy, Medical Audit Program of the Commission on Professional and Hospital Activities, Ann Arbor, Mich., Report No. 11 (September) 1959. Vergil N. Slee, director.



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Operating Room Forum

How To Package O.R. Linens To Assure Greater Sterility

By Frances Ginsberg, R.N.

NO ONE would take a steamer trunk full of clothes on a week-end trip, nor would he try to wash his hands with gloves on. These two *non sequiturs* and rather remote analogies seem far removed from the subject of operating rooms, but they apply to the way operating room bundles should be packaged for efficiency and sterility.


Frances Ginsberg

An old idea still persists that bundles should contain everything that needs to be autoclaved and can be fitted into a bundle which, in turn, will fit into the autoclave chamber. **I contend that O.R. bundles should contain only what can reasonably be expected to be needed and, further, should only include linen, and not basins, instruments or other metal objects. In this way, properly sterilized bundles can be prepared for major and minor surgery.** Although a "D & C" or "T & A" requires less linen and equipment than a cholecystectomy or herniorrhaphy does, all need sterile equipment.

A more important reason to limit the size and contents of all linen bundles is to assure sterility. Steam under pressure must be allowed to contact, saturate and penetrate every portion of every object in the bundle. Therefore, the bundle's size and density should be limited not only to assure effective sterilization but also to reduce sterilization time.

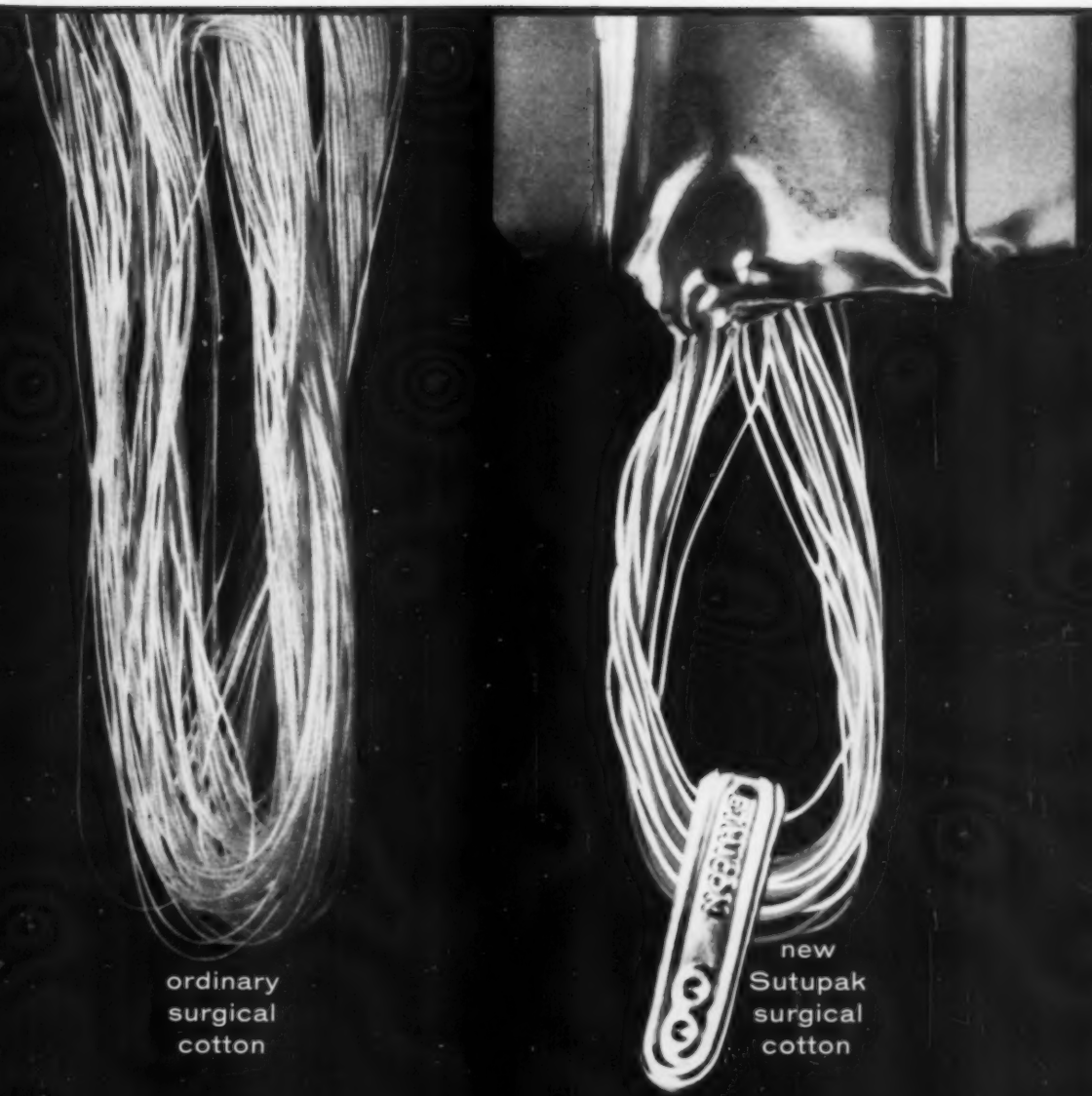
If a basin is fitted over a portion of the linen, the steam reaches neither the inside of the basin nor the linen it covers. It is simple and logical that two good bundles are better than one bad one; equipment that is omitted from one bundle can easily be sterilized in another. Furthermore, it is easier to have a bundle a nurse can handle, rather than one that requires four strong men to lift it off the shelf.

To achieve the recommended standard for sterilization of these articles, 30 minutes' exposure at 250 F., these simple rules should be followed:

1. Use freshly laundered, well hydrated linen.
2. Use four thicknesses of muslin for the outer wrapper.
3. Fan-fold linen.
4. Reduce density of the pack by distributing smaller articles within the larger pieces.
5. Wrap the bundle loosely.
6. Secure bundles with autoclave tape, string, clothesline or webbed tape with buckle, avoiding the use of pins.
7. Load bundles into the autoclave on their sides without crowding.

Although some of these suggested procedures conflict with some old, well established concepts, they cannot only be justified by recognized studies but also by the principle that the only thing constant in life is change. ■

Miss Ginsberg is a consultant on operating room nursing and hospital aseptic technics and a member of the Bingham Associates Program at Boston's New England Center Hospital.



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FOOD AND FOOD SERVICE

How To Staff an Efficient Tray Line System

This system of tray handling, as used at Mound Park Hospital, breaks down the serving task into 26 elements, and thus permits accurate assignment of jobs and personnel

Ruddell Reed Jr.

TRAY preparation is largely dependent upon the method of tray handling for distribution. The primary objective is to get the food to the patient in the best possible condition in an economical manner.

There are three basic methods for tray handling from the dietary department to the patient:

1. Carts or carrying from floor kitchens.
2. A belt-and-arm-lift conveyor system from a central kitchen.
3. Carts from a central kitchen.

Carts or trays carried from floor kitchens. There is little advantage in the use of the floor kitchen except the psychological one of having preparation close to the point of serving. It requires excessive quantities of food and excessive personnel since each kitchen tends to duplicate the operations of all the others and none is large enough to gain the advantages of volume production. The proportion of food waste to total food prepared is higher than in a central kitchen using equally good estimating methods. Furthermore, employes are required to perform a variety of jobs, which reduces their efficiency compared with that possible under more specialized job assignments.

The frequently stated advantage of better preparation because of the small quantities is not achieved because of the quality variation between individual kitchens as compared to a competently operated central system with proper recipes, preparation scheduling, and control. Small portions create waste and inconsistency.

The belt-conveyor and arm-lift system has distinct advantages. It provides the most rapid handling from kitchen to service floor, through wall sections free of hospital traffic. This system can also be used to pace the distribution of food to the patients. The two main disadvantages are difficulty in pacing the belt and lack of means to control the condition of the food. An excessive number of persons must be at the conveyor discharge point to keep trays removed or trays will back up and, unless exces-

Table 1 — Elemental Operations for Tray Assembly Line

No.	Element	No.	Element
1	Pick up menu	12	Place lemon and iced tea spoon as required
2	Call hot food	13	Place bread and bread plate on tray
3	Separate hot and cold portions of menu or menu and tray ticket	14	Place butter on bread
4	Place hot menu on line	15	Place sugar and cream on tray
5	Place tray and tray cover on line	16	Place jelly on tray
6	Place cold menu on tray	17	Place salad on tray
7	Place napkin and knife on tray	18	Place dessert on tray
8	Place fork and spoon on tray	19	Inspect and serve hot bread
9	Place soup spoon or juice glass on tray	20	Place cold tray on cart
10	Place salt and pepper on tray	21	Place hot foods in cart
11	Place milk and 240 cc. glass on tray, iced tea and bread plate, or coffee substitute, or tea or coffee saucer.	22	Place hot bread and/or soup in cart
		23	Serve meat
		24	Serve starch
		25	Serve vegetable
		26	Serve soup

Steps in the assembly of trays are broken down into the above elements with proper positioning of items on line to ensure efficient assignment.

Mr. Reed is a professional engineer and associate professor of industrial engineering, University of Florida, Gainesville. This is the second of two articles. The first appeared last month.

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sive storage space is provided, jam or stop the system.

If storage is provided and trays remain on it, hot food cools and cold food warms because its temperature cannot be controlled during transport and storage. This last is the second major disadvantage of this system. An excessive amount of labor must be available at mealtime with this system and proper storage is impossible; but where floor personnel handle tray delivery to the patient, this system offers the lowest labor and operating cost conditions.

Food Carts Require Storage

This leaves the third system — the use of food carts. The main disadvantages of this system are the necessity for providing storage space for the carts themselves during the time required for cart cleanup, and the extra tray handling to load and then unload the carts. Other disadvantages to the carts, such as cold food or dry food, can be overcome by proper scheduling of cart distribution to the patient floors and of tray distribution to the patients.

The time between tray preparation and delivery to the patient can be scheduled to approach that of the conveyor system with the added advantage of providing the best available storage method for prepared trays when unforeseeable conditions delay delivery. It does, however, require more personnel than the belt-conveyor and arm-lift system in order to distribute the carts to the serving areas and to remove and complete make-up of patient trays.

When all factors are considered, the cart method appears to offer the best solution if consistency of quality of food delivered to the patient is the primary objective. How then can the effects of the disadvantages of storage, time for tray loading, and delay in transit be held to a minimum? The obvious answer is to have the carts moved from the kitchen immediately after loading and the food distributed at once after reaching the patient floor.

At Mound Park Hospital, St. Petersburg, Fla., we have found that a tray can be prepared from the cart for delivery to the patient in approximately 0.75 minutes if all items are properly located on and in the cart. This means that if one person prepares trays while others deliver, a 20 tray cart can be unloaded in 15 minutes. If one hour is accepted as the normal feeding period, one girl can handle four cartloads if the distance between cart locations is not excessive. Furthermore, during the feeding period, other floor activity, except that of an emergency or scheduled nature, is slackened, thereby making floor personnel available for food distribution to the patient. A work sampling during these periods at Mound Park showed that the average amount of personnel available exceeded actual requirements for tray delivery to patients.

Most carts are designed to handle cold food on a tray in a cooled compartment and hot food on dishes in a warmed compartment. In common practice, hot foods are loaded on a tray traveling along a conveyor or table and then removed and loaded on a sliding drawer in the warmed compartment of the cart. This requires an extra handling for each hot container.

Another method is to load the cart with the cold trays and then move it to another position for loading hot food. This is an extra move with unnecessary storage of cold food in the cart and also is conducive to errors in matching hot and cold foods for an individual patient.

Containers May Be Too Hot

Another system is to load hot food in an insulated container. This requires extra heating of the hot food dishes to a temperature for which special handling equipment is required, which indicates a hazard.

The most desirable cart-loading system is one that will:

1. Load cold and hot food simultaneously, thereby holding loaded storage to a minimum.

2. Permit handling of hot food dishes in assembly without the need for extra tray loading and unloading and without the use of excessively hot containers.

A belt conveyor with multiple loading stations best meets these objectives. Elemental operations for assembly with proper positioning of food items on the line are given in Table 1. Job elements can be as-

Table 2 — Personnel Requirements for Tray Assembly Assignments

Personnel Required for Various Line Capacities per Hour

Capacity (Trays)	Allowable Time per Operation for Completion in One Hour	Assemblers Including Caller	Correction Girls	Cart Boys (dependent upon distances carts must be moved)	Cart Girls (min.)	Total
100	0.6	2	0	0	2	4
200	0.3	3	0	1	3	7
300	0.2	5	0	2	4	11
500	0.12	9	1	3	7	20
600	0.10	10	1	4	8	23
750	0.08	14	1	5	10	29
1000	0.06	18	2	7	13	40

Summary indicates the number and types of employes who would be required to operate the cart assembly and food distribution system for various capacities of installations, based on one hour for the entire operation.

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signed by various combinations to the required number of operators necessary to provide the required number of trays in the desired time cycle.

Table 2 (see *p.* 140) provides a sample summary of the number of employes by types required to operate the cart assembly and food distribution system for various size food service installations.

Serving 1000 trays from a single line is the approximate practical limit. At 750 or more, it will be advantageous to either establish two assembly lines, extend the feeding period, or intersperse menus in the deck for two carts in order that one cart may be loaded from each side of the line.

The tray assembly line shown in Table 1 was designed for Mound Park Hospital combining these operational elements to provide completion of patient feeding in one hour. This line will permit preparation of 600 trays per hour using nine persons on the line plus an additional girl to make corrections to the trays that may be rejected by the dietitian who checks them. The length of the conveyor, the space allocated to individual work stations, and the number of persons used on the line satisfy the patient feeding requirements while using available floor area with minimum alteration of existing layout and structure. Within the limitations of department space and the elemental operation of Table 1, a similar assembly line can be designed to meet the requirements of any installation. ■

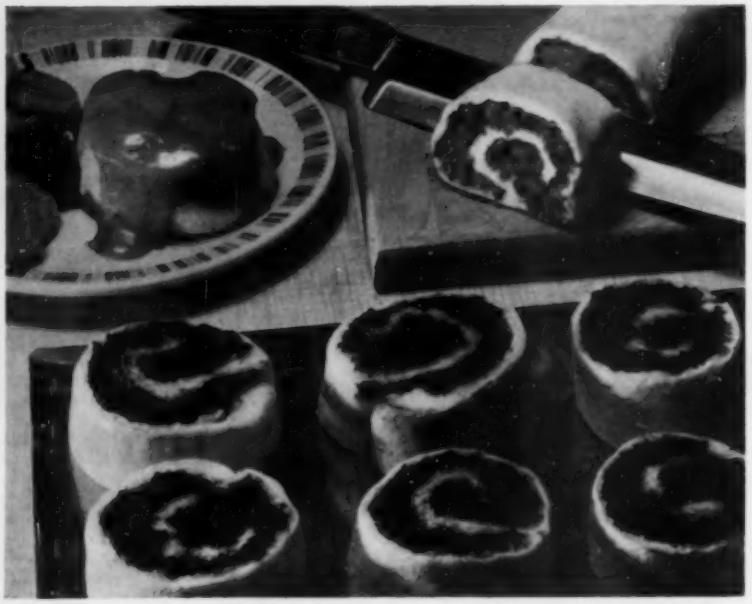
Instant Potatoes Can Be Whipped Into Glamorous Dishes

SPECIAL diets, off-hour meals, and even everyday service can be simplified through use of instant mashed potatoes. Packaged in powdered form, they are simply whipped into water and milk.

Where the labor load is heavy, the instant potatoes may produce real savings, according to Catherine Turner, assistant professor of home economics at the University of Alabama. They are also convenient to use where only small amounts are needed for special purposes.

The instant potatoes can be used plain or as a base for hash, fish cakes, soup, in casseroles, or in special dishes such as beef pinwheels.

The speed with which the basic mashed potatoes can be prepared makes them especially practical for use in "dressed-up" versions such as the duchess potatoes suggested by Miss Turner. ■



DUCHESS POTATOES

Servings: 25 of ¾ cups each.

Ingredients	Amount
Instant mashed potatoes	1 lb., 8 ozs.
Boiling water	1½ quarts
Salt	1 tablespoon
Butter	½ cup
Scalded milk	1 quart
Eggs	4

1. Prepare instant mashed potatoes according to package directions, using above proportions of water, salt, butter and milk.
2. Add eggs gradually, beating to blend.
3. Force through pastry tube onto greased baking sheets to form mound or nest.
4. Brown in a hot oven (450 F.) for about 10 minutes.
5. Use as a topping for casseroles or pour a sauce over the potato mound.

BEEF PINWHEELS

Servings: 48

Ingredients	Amount
Ground beef	3 pounds
Chopped onions	1 quart
Salt	1 tablespoon
Potatoes, mashed, seasoned	1 quart
Ketchup or chili sauce	1 pint
Eggs	4
Biscuit mix	5 pounds

1. Brown meat and onions; sprinkle with salt.
2. Mix in potatoes, ketchup and eggs; chill thoroughly.
3. Prepare biscuit mix according to package directions. Divide dough into 4 parts. Roll each part into a rectangle (18 by 10 by ¼ inches). Spread each rectangle with 3 cups meat mixture; roll lengthwise. Cut into 1½ inch slices.
4. Place slices, cut side down, on greased baking sheets. Bake in a 400 F. (moderately hot) oven 15 minutes or until biscuits are done.

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Whatever is important in the many-faceted hospital field has the right of way in THE MODERN HOSPITAL: the green light is always on—there's no orange beam to slow down any new idea or project or method that promises to be meaningful; no red light, ever, to halt what is significant while the parade of group opinion passes.

That, we believe, is the responsibility and strength of independent journalism—to inform readers of what is important, immediately, and to help them to make informed judgments on what is of concern to the health field.

For example: our editorial coverage of two of the most significant and far-reaching developments in hospital service in the past twenty years—progressive patient care and the rising tide of unionization of hospital personnel. In June 1957, two full years before other hospital magazines recognized the true significance of progressive patient care, THE MODERN HOSPITAL initiated a continuing series of reports on this revolutionary idea in caring for the sick. As early as March 1959 this magazine published in a single issue detailed plans and methods of five hospitals, old and new, in which the principles of progressive care of hospital patients had been incorporated in whole or in part. For several years, THE MODERN HOSPITAL has been reporting on the increasing weight of unions among hospital personnel and the new problems arising from union demands, presenting all the facts of both hospital and labor activity. In fact, almost alone in its field, THE MODERN HOSPITAL has treated this vital issue continuously, comprehensively and on a national scale.

The most arresting articles that will appear in the next few months in THE MODERN HOSPITAL have not yet been written—for the very good reason that the events and developments which they will report haven't yet happened. We believe that our responsibility as journalists is to report what is important *when* it is important—and we never have to wait for anyone's orange light.

THE MODERN HOSPITAL PUBLISHING CO., INC.
919 NORTH MICHIGAN AVENUE, CHICAGO 11, ILLINOIS

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FOOD FOR THOUGHT

How To Select Chinaware That Wears Well

Good buying technics and proper handling of food and major equipment are always of concern to dietary departments. Sometimes, however, they neglect to extend this same care to the selection of such items as tableware, according to a home economist.

China must be given special attention because it is the background for food, Catherine Turner, assistant professor of home economics at the University of Alabama, advises. Some colors, for example, do not enhance the natural colors of foods. Quite often, she points out, chinaware that looks attractive appears quite different with food on it.

Other advice offered by Miss Turner on the selection of chinaware for use in hospitals includes:

Weight. The weight of china one chooses depends upon the care it will receive. Years ago it was necessary to use a heavy china where it would receive hard wear. This is no longer true. Manufacturers have designed a rolled edge that reinforces the piece at the point where it receives the greatest amount of bumping. This allows the rest of the piece to be thinner. This edge also decreases the contact surface when the pieces are stacked and thus reduces scratching.

Size. In literature on chinaware the terms "trade size" and "actual size" are often used. Trade size is a manufacturer's term and usually denotes a size smaller than the actual size of the piece. The actual size usually refers to the over-all size of the plate or from rim to rim.

Sizes of cups are specified in ounces and also by the terms coffee cup and tea cup. It is well to investigate to see which size best suits the hospital's purpose.

It is best to keep shapes and sizes of pieces to a minimum by selecting those that have many uses. A large bread and butter plate, for example, can also be used for a small salad, an underliner for a soup bowl, or as a dessert plate. Irregular shapes require more space for handling and stacking, and therefore should be avoided.

Grade. The terms "firsts" and "seconds" refer to the grade of chinaware. Firsts refer to china of highest quality and are the most perfect pieces. Seconds, although less expensive to purchase, may result in an increase in breakage equal to the savings. They are pieces that warped in the firing, or have other defects. These warped pieces may cause stacked pieces to topple.

Design. Attention should be given to the method of applying the design. Note whether the design has been printed or applied under the glaze. When the design is applied on top of the glaze, it will be removed by the friction of the pieces rubbing together. It may also be weakened by the action of the detergents and other chemicals used in washing chinaware. For the most satisfactory use, the design must be under the glaze. ■

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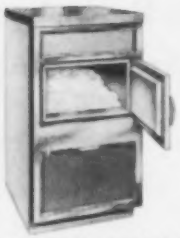

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Leftover Bread Can Rise Again — in New and More Appetizing Dishes

DESPITE careful planning and purchasing, there is often leftover bread in any dietary department. **Patients recognize breads that are reheated and served to them, but there are other ways to use these leftovers in economical and appealing dishes.**

Edible day-old bread can be used as an ingredient in entrees, desserts, as stuffings for fish and poultry, and in combinations with meat. Bread also can be used to advantage as croutons for soup and as bread sticks to be served with salads.

Leftover bread and rolls can also be used to create new dishes that will tempt patients' appetites and, at the same time, save money for the department. The use of enriched or whole wheat bread in recipes adds to the nutritive value of meals. ■

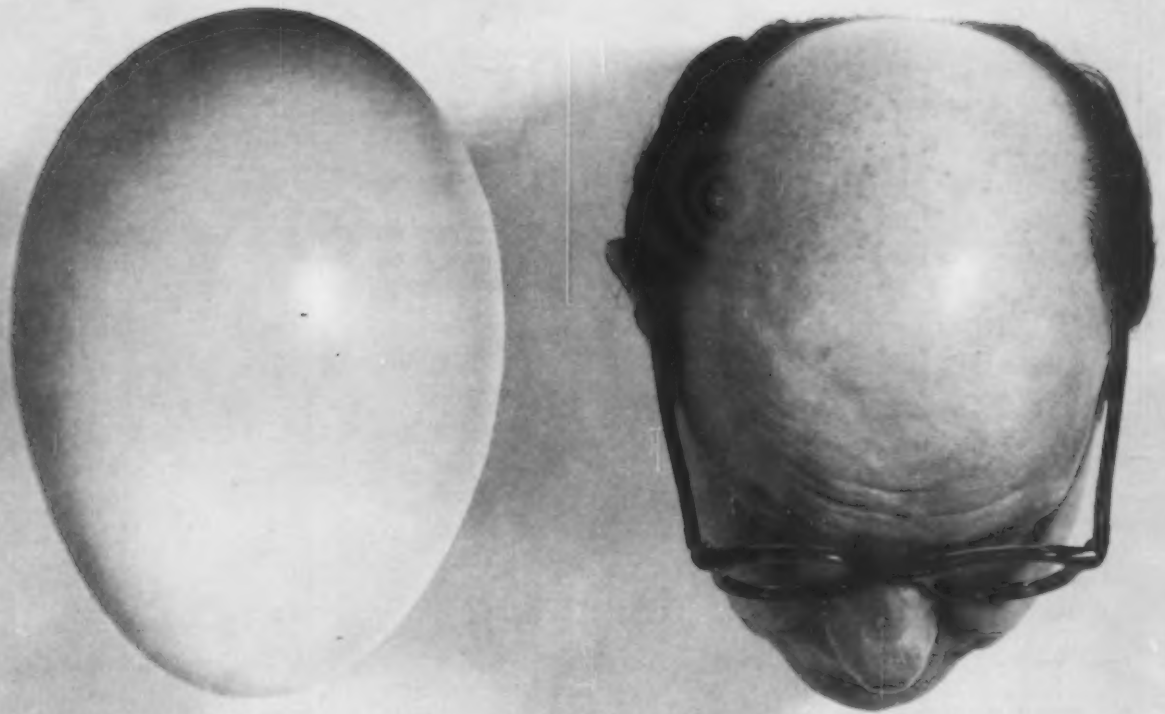
BREAD AND CHEESE SOUFFLE

Portion: 24 servings per pan — Yield: 48 servings

Ingredients	Measure	Weight or Amount
Butter or margarine	1½ cups	¾ pound
Flour	2¼ cups	10½ ounces
Salt	2 tablespoons	2 tablespoons
Cayenne pepper	½ teaspoon	½ teaspoon
Milk, whole fluid	3 quarts	6 pounds
Processed cheese, grated	1½ quarts	1½ pounds
Egg yolks	2 cups	1 pound
Bread cubes, fresh	1 gallon	1¼ pounds
Egg whites	3 cups	1½ pounds

1. Melt butter in a large saucepan.
2. Blend in flour, salt and cayenne pepper.
3. Add milk and cook until thick, stirring constantly.
4. Add cheese and stir until cheese melts.
5. Beat egg yolks.
6. Gradually add cheese sauce in beaten egg yolks.
7. Add bread cubes and mix well.
8. Beat egg whites until stiff and dry. Fold into cheese mixture.
9. Pour mixture into two greased 12 by 20 by 2½ inch baking pans.
10. Bake in a slow oven 300 F., for 1¼ hours. Serve immediately.

This golden bread and cheese souffle is one example of how leftover breads can be used as the main ingredient in appealing and economical dishes.



the problem... **the solution**

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Menus for June 1960

Mary Harman Riste
Executive Dietitian
Butterworth Hospital
Grand Rapids, Mich.

1

Half Grapefruit
Scrambled Eggs

•

Chicken Soup
Saute Veal Loin Chop
Baked Potato
Cut Wax and Green Beans
Fruit Cup Gourmet
Toasted Angel Cake

•

Vegetable Soup
Larded Beef Tenderloin
French Fried Potatoes
Romaine With Vinaigrette
Cherry Pie

2

Melon
Steamed Egg

•

Cream of Celery Soup
Roast Beef au Jus
Noodles in Beef Juice
Perfection Salad Mold
Peach Cobbler

•

Fruit Cup With
Candied Mints in Grapes
Larded Veal Loin
With Fine Herb Sauce
Persillade Potatoes
Beets
Cheese Cake

3

Sliced Orange
French Toast, Sirup

•

Lime Juice Cocktail
Seafood Croquette
Scalloped Potatoes
Fresh Cooked Spinach
Strawberry Cream Pie

•

Cream of Tomato Soup
Cheese Souffle
Fresh Asparagus
Fruit Salad Bowl
Toasted Almond Ice
Cream

4

Half Grapefruit
Soft Cooked Eggs

•

Eggdrop Soup
Baked Canadian Bacon
Scalloped Corn
Broccoli
Relish Plate
Pumpkin Pie

•

Consomme
Chicken Rice Timbale
Asparagus Tips
Pear Salad Naturelle
Neapolitan Parfait
Coconut Snowball Cakes

5

Orange Juice
Soft Cooked Egg

•

Golden Nectar
Chicken Pie, With
Biscuits
Mashed Potatoes
Mixed Vegetables
Celery, Spiced Apricot
Pistachio Ice Cream

•

Beef and Rice Soup
Fresh Asparagus Tips
on Toast Points
Crisp Bacon Strips
Fruit Salad
Devils Food Cake

6

Fruit Juice
Pancakes, Sirup

•

Noodle Soup
Roast Leg of Lamb
Parslied New Potatoes
Green Peas Wanda
Stuffed Prunes With
Cheese
Grapefruit Sherbet

•

Vegetable Soup
Grilled Hamburger Steak
Clubbed Potato
Bibb Lettuce With
Roquefort Cream Dressing
Cherry Roll

7

Tomato Juice
Poached Egg on Toast

•

Cranberry Juice Cocktail
Fried Spring Chicken
Tubed Potatoes, Gravy
Sliced Water Chestnuts
Floating Island

•

Schnitzlebank Pea Soup
Turkey Sandwich
Buttered Broccoli
Fruit Salad Bowl
Chocolate Sundae

8

Prunes With Orange
Soft Cooked Egg

•

Consomme Royal
Roast Leg of Lamb
Rice Pilaf
Parslied Carrots
Tossed Greens
Mandarin Oranges

•

Puree Mongole
Knickerbocker Supreme
of Chicken With Sauce
Broccoli
Chopped Potato Salad
Compote of Fruit

9

Orange Juice
Poached Egg on Toast

•

Tomato Juice
Roast Leg of Veal on
Herb Dressing
Pan Browned Potatoes
Fresh Spinach
Danish Custard

•

Asparagus Soup
Broiled Tenderloin Steak
Sauteed Mushrooms
French Fried Potatoes
Caesar Salad
Baked Fresh Rhubarb

10

Half Grapefruit
Soft Cooked Egg

•

Cream of Tomato Soup
Scrambled Eggs on
Parmesan Toast Points
French Fried Potatoes
Fresh Asparagus
Grapefruit, Bacon and
Avocado Salad
Coconut Cream Pie

•

Lime Juice Cocktail
Broiled Whitefish
Waffled Potatoes
Buttered Tiny Beets
Burnt Sugar Cake

11

Sliced Orange
Broiled Bacon

•

Beef and Barley Soup
English Mixed Grill
Creamed Potato Balls
Broccoli
Celery Hearts, Olives
Pineapple Dessert

•

Borsch
Pennsylvania Meat Loaf
Stuffed Potatoes
Artichoke Salad Aveline
Lemon Meringue Pie

12

Grapefruit Juice
Scrambled Eggs

•

Melon Ball Cocktail
Rib Roast of Beef
Mashed Potatoes
Fresh Asparagus With
Hollandaise Sauce
Chocolate Ice Cream

•

Noodle Soup
Creamed Chipped Beef
in Parsley Crustades
Sauteed Mushrooms and
Green Frozen Peas
Fruit Salad Bowl
Chocolate Eclair

13

Orange Juice
Pancakes, Maple Sirup

•

Consomme Julienne
Roast Turkey Breast on
Rice and Mushrooms
Giblet Gravy
Fresh Asparagus Tips
Pear and Cheese Salad
Pistachio Ice Cream on
Sponge Cake

•

Nectar With Fruit
Baked Veal Chop
Mixed Vegetables
Marble Layer Cake

14

Honeydew Melon
Broiled Sausages

•

Cream of Corn Soup
Roulade in Brown Sauce
Mashed Potatoes
Buttered Celery and
Mushrooms
Small Relish Plate
Blanc Mange Mold

•

Vegetable Soup
Bacon, Tomato Sandwich
Pickle Chips
Jellied Fruit Salad
Caramel Ice Cream

15

Orange Juice
Soft Cooked Egg

•

Tomato Bouillon
Pot Roast of Beef
Mashed Potatoes With
Brown Herb Gravy
French Fried Asparagus
Celery Hearts
and Carrot Shreds
Glazed Peach Tarts

•

Fresh Pineapple Cubes
Fried Smoked Ham
Scalloped Potatoes
Broiled Tomato
Spice Cake

16

Half Grapefruit
Broiled Bacon

•

Cranberry-Orange Juice
Fried Spring Chicken
Glazed Sweet Potatoes
Buttered Green Beans
Vanilla Ice Cream

•

Cream of Tomato Soup
Yum Yum Sandwich
Potato Chips
Mixed Pickle Garnish
Fresh Fruit Cup

17

Fresh Strawberries
Coffee Cake

•

Golden Fruit Cup
Fried Mock Scallops
New Potatoes
Sliced Carrots
Chocolate Chiffon Pie

•

Clam Chowder
Shrimp Chow Mein on
Toasted Noodles
Buttered Broccoli Tips
Plate of Sweets

18

Prunes With Orange
Poached Egg on Toast

•

Cream Princess Soup
Beef Stroganoff on Rice
Broccoli, Lemon Butter
Bibb Lettuce Rose With
Aveline Dressing
Fruit Lorette
Cereal Cookies

•

Roast Leg of Lamb
Mashed Potatoes, Gravy
Peas and Carrots
Jellied Fruit Salad
Chocolate Angel Cake

19

Fresh Grapefruit
French Toast, Sirup

•

Oxtail Soup
Corned Beef Brisket
Potatoes O'Brien
Spinach Souffle
Small Relish Plate
Pumpkin Pie

•

Tomato Juice Cocktail
Veal Casserole
French Green Beans
Bibb Lettuce With
Orange Slices
Custard Ice Cream

20

Melon
Soft Cooked Egg

•

Chicken Fricassee
Mashed Potatoes With
Parsley Gravy
Macedoine of Vegetables
Pepper Slaw on
Bibb Lettuce
Peach Cobbler

•

Vegetable Soup
Hamburger in Rusk Bun
Potato Salad in Romaine
Fresh Fruit Cup
Icebox Cookies

21

Fresh Strawberries
Scrambled Eggs

•

Beef and Mushroom Loaf
Diced Potatoes au Gratin
Whole Green Beans
Jellied Fruit Salad
Orange Layer Cake

•

Cream of Carrot Soup
Shepherds Pie With
Tubed Potatoes
Fresh Asparagus Tips
Coupe Louisiana
Chocolate Frosted Cookie

22

Blended Juice
Poached Egg on Toast

•

Mushroom Soup
Sliced Sirloin Steak
Alphonso Potatoes
Pickle Relish, Olives
Cherry Pie

•

Chinese Soup
Macaroni and Cheese
Broccoli
Bibb Lettuce With
Celery Seed Dressing
Strawberry Shortcake

23

Orangrade
Broiled Bacon

•

Consomme Julienne
Roast Tom Turkey
Tubed Potatoes
Carrots and Peas
Stuffed Celery Hearts
Tutti-Frutti Parfait

•

Cream of Corn Soup
Chicken and Ham
Sandwich, Potato Chips
Watermelon Pickle
Jellied Fruit Salad
Fudge Loaf Cake

24

Half Grapefruit
Soft Cooked Egg

•

Meatless Vegetable Soup
Broiled Whitefish
Stuffed Potatoes
Paprika Cauliflower
Fresh Fruit Salad
Black Bottom Pie

•

Cream of Spinach Soup
Toasted Cheese on
Crackers
Egg Souffle on Mushrooms
Chef's Salad Bowl
Peach Sundae
Coconut Layer Cake

25

Honeydew Melon
Soft Cooked Egg

•

Roast Veal, Dressing
Potatoes O'Brien
Buttered Green Beans
Sliced Tomato, Lettuce
Chocolate Pie

•

Consomme Royal
Baked Trout
Spanish Rice
Small Relish Plate
Sliced Peaches
Sugar Cookie

26

Half Grapefruit
Scrambled Eggs

•

Tomato Juice
Swiss Steak
Mashed Potatoes
Buttered Peas
Prune Whip

•

Cream of Celery Soup
Poached Egg and
Canadian Bacon on
Buttered Rusk
Buttered Broccoli
Fruit Salad Bowl
Date Torte With
Ice Cream Topping

27

Orange Juice
French Toast, Sirup

•

Noodle Soup
Baked Ham
Glazed Sweet Potato
Buttered Fresh Spinach
Pink Lemonade Sherbet
Lady Baltimore Cake

•

Cream of Asparagus Soup
Roast Beef Rump
Parslied Potatoes
Harvard Diced Beets
Bunch of Greens Salad
Orange Bread Pudding

28

Honeydew Melon
Soft Cooked Egg

•

Sauteed Spring Chicken
Mashed Potatoes
Buttered Green Beans
Celery Hearts
Baked Rhubarb
Sand Tart Cookie

•

Cream of Pea Soup
Creamed Chipped Beef
on Buttered Rusk
Fresh Asparagus Tips
Butterfly Salad
Key Lime Pie

29

Tomato Juice
Poached Eggs

•

Cream of Mushroom Soup
Frenched Haddock Fillets
Latticed Potatoes
Fresh Green Spinach
Green Citrus Cocktail
Maraschino Icebox Dessert

•

Chicken-Rice Soup
Scrambled Eggs on
Melba Toast Points
Asparagus Tips
Fresh Fruit Salad
With Avocado
Butter Layer Cake

30

Pineapple Juice
Broiled Bacon

•

Mushroom and Celery
Soup
Broiled Ground Steak
Mushrooms Julienne
Fordhook Limas
Tossed Salad
Fresh Pineapple
and Banana

•

Grilled Lamb Chop
Scalloped Potatoes
Green Salad
Fresh Fruit Cup
Toasted Angel Cake

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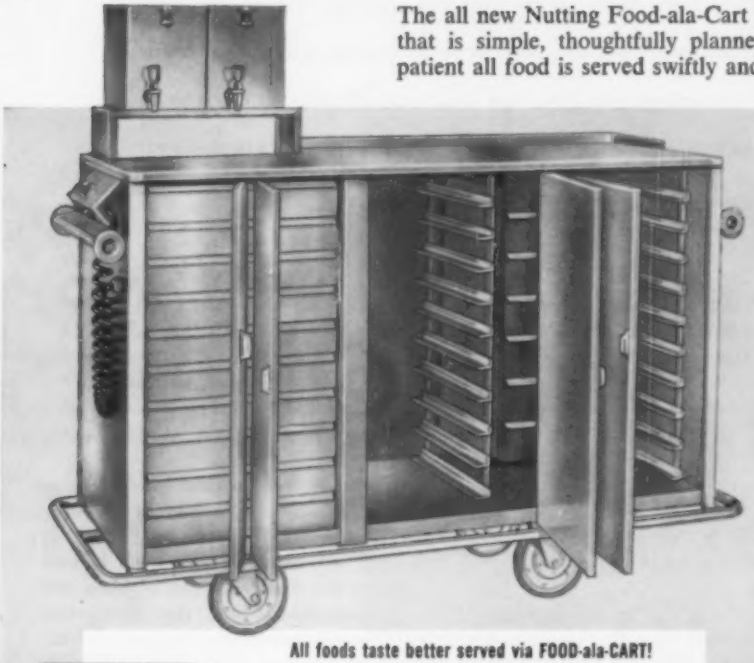

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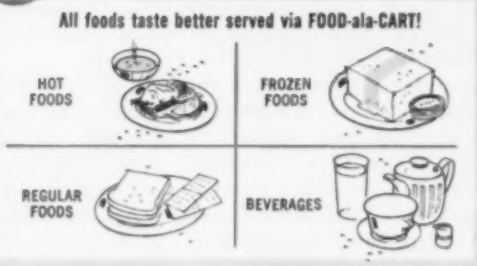

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(Fig. 1919-ST)
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(Fig. 892)
LINEN AND
LAUNDRY TRUCK


(Fig. 845)
PLATFORM TRUCK


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ROUND CONTAINER
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How To Disinfect Blankets and Pillows

This study analyzes the technics used to sterilize blankets and pillows, both of which have been indicted as agents for spreading infection, and evaluates those that have been reported effective from the standpoints of safety and cost

Wolfgang Haas

CONTROL of infections within hospitals has been made more difficult by the fact that the activities of so many people are involved. Not only are they assigned to many different departments, but they also vary greatly in training and intelligence. The nurse and the physician must observe the proper procedures. However, the most meticulous aseptic technic in the operating room can be made worthless by a janitor who fails to clean it properly or a ventilating system which brings contaminated air into the room. Sterile equipment and superior care in the delivery suite may be of no value if the postpartum patient is then transferred to a bed with a mattress, sheets, blankets, and a pillow that are contaminated by pathogenic organisms.

Although consideration must be given to all segments of infection control within hospitals if the patients are to be safe, each phase of the problem must be studied individually. The reasons for this are obvious. The problem of providing clean linen is quite different from that of keeping a carrier of staph infection out of the newborn nursery; the problem of cleaning floors properly is different from that of preventing back-siphonage into the water system. Even though a common body of knowledge must be applied to all such problems, each one must be considered specifically in light of the materials, personnel and technics that are involved. **In this paper, one segment of the problem of controlling infection within the hospital will be considered:**

How is the spreading of infection within hospitals by blankets and pillows to be avoided?

This paper had its genesis in the programing of the remodeling of the existing buildings that will follow the opening of a 10 floor addition to Mount Sinai Hospital of Cleveland. This programing has been the occasion for review and reconsideration of a number of presently accepted procedures.

Problem Poses Questions

While considering what additional sterilizing equipment was to be acquired, it was suggested that an ethylene oxide sterilizer be installed to disinfect the blanket and pillow used by each patient following the discharge of that patient. This proposal was not prompted by the existence of an infection problem, but rather by a desire to set up one more barrier to the possible spread of infection. **I was assigned the task of evaluating the suggestion and of providing answers to two questions raised by it:**

1. Is there a need for routine disinfection of blankets and pillows?

2. If there is such a need, what is the best method of disinfecting them?

The answers to these two questions will provide the answer to our original question.

It was thought reasonable to consider the disinfection of blankets and pillows apart from the disinfection of other parts of the hospital environment because they are significantly different:

1. Unlike sheets, pillowcases and other cotton goods, pillows and most blankets cannot be subjected to repeated high temperature washing.

2. Unlike mattresses, they cannot be covered with a rubber or impervious plastic cover which can be wiped with a disinfectant.

3. Unlike furniture, fixtures, walls and floors, they cannot be wiped with a disinfectant.

The literature dealing with the disinfection of blankets and pillows is often also concerned with the disinfection of the bed, the mattress, the sheets, and the pillowcases. Since this material was available and since, in the operating situation, there would generally be a desire to review the adequacy of disinfection of the patient's whole environment, some general remarks about the disinfection of these other components of a bed

---

This is the first section of an article on disinfection of blankets and pillows condensed from a master's thesis prepared by Mr. Haas as part of the program in hospital administration at the University of Michigan. Succeeding sections will discuss methods of washing pillows, other technics of disinfection, and general problems of handling and transportation.

The author is administrative assistant and office manager, Sherman Oak- Community Hospital, Sherman Oaks, Calif.

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will be made in a special article to be presented in a subsequent issue.

One point that should be made clear at once is that the discussion that follows is concerned with the bedding of the "normal patient." There will be no attempt to consider handling or treatment of blankets and pillows that have been used by patients who are "on isolation" because of the communicable nature of their ailment. This is a separate and somewhat different matter.

The very considerable contamination of the blankets in hospitals by microorganisms, both pathogenic and other, has been amply demonstrated by many investigators. Regardless of the conclusions that are reached on the question of the relative importance and role of airborne organisms *versus* those transmitted via fomites in causing infections, there is no question that blankets can be and are sources of infection in hospitals unless they are disinfected. There may be direct contamination of a wound or catheter, even though they are covered with sterile dressings and sheets. Movement of the blankets and pillows will disseminate any microorganisms on them through the air.

Experiments Reduced Bacteria

The statement that blankets may be the cause of infection is supported by the direct evidence of situations in which improved blanket cleaning procedures resulted in a reduction of the number of hospital-acquired infections experienced by the patients, the indirect evidence of experimental situations when reduced bacterial populations were found in the air after improved blanket disinfection procedures were put into effect, and the opinions of workers in the field.

The paucity of direct evidence can be ascribed to the fact that, in the operating hospital situation, an improvement in the disinfection of blankets is almost always only one of a number of changes in practice. Since these changes are instituted at the same time, it is impossible to determine which changes produced whatever improvement is reported.

Assuming that blankets and pillows are contaminated with pathogens by their users or from the atmosphere, is there a possibility that those that are contaminated can be identified for separate treatment? If they could be, it would be of considerable value since it would reduce the number that require disinfection and thus reduce the cost. Many hospitals have, in practice, assumed that such a differentiation can be made. They wash, air, sterilize or otherwise treat their blankets and pillows only when they appear "dirty" or after use by an infected case.

It appears, however, that there is no basis in fact for this assumption. Frisby states: ". . . hospital blankets, unless specially laundered, are bacteriologically contaminated and potentially dangerous . . . blankets may be heavily contaminated and still appear quite clean . . . carriers of pathogenic organisms can contaminate blankets as heavily as an overt case."[1]

The airborne microorganisms, which can so often be found in ample supply in hospitals, can settle on blankets without being evident. Likewise, the pillow that has been heavily contaminated by the saliva or nasal secretions of its user will generally not show any visible evidence of this contamination.

The only safe and valid assumption that can be made, therefore, is that any blankets or pillows that have been used by a patient are contaminated. This means that they must be subjected to disinfection after each discharge. Each patient admitted must receive fresh items.

Before evaluating various technics of disinfection as to their applicability, efficacy and cost, a standard must be established. This standard would specify the level of contamination by microorganisms of the disinfected object that will be allowed as acceptable. In the case of surgical instruments the acceptable level allows the presence of no living microorganisms; good hand washing leaves a great number. Both are acceptable technics for different situations.

For purposes of this study, a technic of disinfection of blankets and pillows will be considered acceptable if it leaves only a minimal amount of contamination; sterility will not be required. This standard is accepted by authorities in the field of hospital sanitation and is reasonable in light of the fact that as soon as a blanket or pillow is put into use, it is recontaminated by its environment. What constitutes an acceptable minimal amount requires the judgment of a qualified person in each case. For the purposes of this study, the statement of a person who appears qualified by reason of his position, title and academic degrees and who reports his work in a professional journal, to the effect that a given procedure is adequate, will be accepted at face value. How to determine whether the procedure that is followed in a specific hospital produces acceptable results will be discussed in a later section of this paper.

[1]Frisby, B. R.: Cleaning of Hospital Blankets. Brit. M.J. 2: 506 (Aug. 31) 1957.

Methods of Disinfection

The various technics of disinfection of blankets and pillows presented here have been recommended in the professional literature in the last few years. These include:

1. Washing (with and without chemical disinfectants)
2. Ethylene oxide
3. Moist heat
4. Dry heat
5. Ultraviolet radiation
6. Formaldehyde

For each technic the following points will be considered: (a) disinfectant efficacy; (b) effect on blanket and pillow materials; (c) acceptability to patients, and (d) costs.

The most that can be said about any technic of disinfection is that it has produced satisfactory results when and where it was tested. A hospital that institutes a disinfection technic different from that it has been using should subject the materials disinfected to bacteriological study to assure that the technic is adequate.

How to conduct such studies and how to interpret the results must, of necessity, be left to the specialists. The administrative staff and the laundry manager can do no more than to arrange for the performance of such tests by the hospital's laboratory or by another institution, such as a university or the local or state health department. The interpretation of the results is a matter for a bacteriologist, the hospital's pathologist, or the infection committee.

Since a relatively minor change in a disinfection technic may have a great impact on its effectiveness, no hospital can have confidence in a new technic, or in its present practices, without testing the results.

(*Continued on Page* 156)

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Methods of Washing Blankets

The commonest method of disinfecting textiles is to wash them. The washing cycle may be bactericidal as well as mechanically removing microorganisms. The following factors are believed to affect the disinfectant effect of washing:

1. Number and type of microorganism initially present.
2. Temperature of suds and rinses.
3. Number and length of suds and rinses.
4. Vigor of agitation.
5. Soap or other detergent used.
6. Degree of souring (agent used, length of time, pH attained).
7. Amount of laundry compared to capacity of washer.
8. Disinfectants used.
9. Bleaches used.
10. Method and temperature of drying.
11. Method and temperature of pressing.

Washing gives the additional benefit of a product that is clean as well as disinfected. This is esthetically pleasing to the patient and means that there is no organic material to foster the growth of organisms that may settle on the blanket or pillow when it is used again.

Wool. Blankets made of wool, alone or in combination with other fibers, are widely used in hospitals. To avoid excessive shrinking and felting, such blankets must be washed at low temperatures, for short periods of time, and with little agitation. Unfortunately, such a procedure does not reduce the microorganism population to an acceptable level of minimal contamination. Subjecting wool blankets to the normal high temperature commercial or institutional washing procedure, which renders laundry essentially sterile, will make them unusable because of shrinkage and felting. A number of disinfectants are available that can be used with short, gentle, low temperature washing procedures to reduce or eliminate pathogen contamination in wool or part-wool blankets.

Synthetic Phenols. Ravenholt et al. have reported studies of a synthetic phenol. From their field trials they conclude that ". . . the synthetic phenol appears to be a suitable compound to use in blanket disinfecting procedures . . . the results . . . demonstrate a practical means of eliminating transmission of staphylococci in hospitals by means of contaminated blankets."[2] Other studies cited by them establish the germicidal effect of this disinfectant on the tubercle bacillus and show that it does not produce textural, odor or color changes in the materials on which it is used or skin sensitivity in personnel who use it.

What It Costs

At the current price of this synthetic phenol, the cost of the material, at the 1 per cent concentration tested and recommended by the Ravenholt group, would be 10 cents per blanket. The Washington State Health Department also recommends the use of a synthetic phenol for disinfecting blankets.[3] Its recommended dilution, however, is 2 per cent. This would double the cost for the disinfectant, making it 20 cents per blanket.

Quaternary Ammonium Compounds. There is a family of chemi-

[2]Ravenholt, O. H., et al.: Eliminating Blankets as an Infection Source. Hospitals. 32:75 (June 16) 1958.

[3]Washington State Department of Health, Division of Epidemiology and Laboratories: Suggested Method for Sanitization of Blankets. (Oct. 18) 1957 (mimeo).

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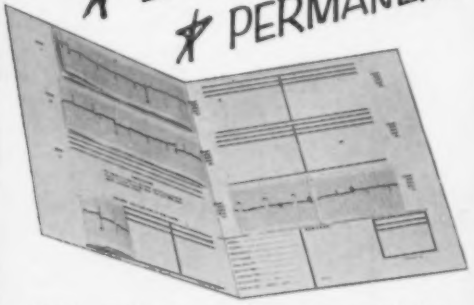

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cals known as quaternary ammonium compounds. Several of these are widely used as disinfectants. They are effective germicides against most microorganisms. Notable exceptions to this are pseudomonas pyocyanea (a pathogen found in urinary tract infections), and the tubercle bacillus. Since the quaternary ammonium compounds are inactivated by soap and by certain types of detergents, they are generally added to the final rinse when used in a washing routine. Walter says: "A quaternary ammonium compound added to the final rinse water will make the textiles actively bacteriostatic. When bedding treated in this manner is subsequently contaminated with respiratory and wound discharges, the bacteria are destroyed rather than distributed."[4] No reports of skin irritation for patients or staff as a result of using quaternary ammonium compounds have been found.

Field recommends the use of quaternary ammonium compounds and reports studies of a number of trademarked products that have been found to be adequate disinfectants against certain bacteria.[5]

He reports that the cost for these materials, to produce an effective concentration, is less than 1 cent per blanket.

It should be noted that the cost of the disinfectant used in any procedure of low temperature washing with a disinfectant is only a portion of the expense involved. The cost of collecting and distributing the blankets after each washing must be included. The usual direct costs in the laundry must be included; these may be higher than for other material processed since, depending on the type of equipment used, special adjustments of the controls or manual operation may be required for the low temperature, gentle agitation, short-run procedure, according to a report of the American Institute of Laundering.

May Increase Depreciation

There may also be some increased depreciation of the blankets owing to repeated washing as compared, for example, to gas sterilization. The expense attributable to this factor is not known. No data have been found concerning the effect of frequent and repeated washing on the life expectancy of blankets. The manager of the laboratory department of the American Institute of Laundering in a recent letter states: "We have never been able to obtain any satisfactory or significant data on the life expectancy of blankets. While wool blankets are affected somewhat by the frequency of washing, blankets washed with proper care should not have their life expectancy reduced to any significant extent."

Synthetic Fibers. Various synthetic fibers are being used to make blankets – orlon, dacron, nylon, acrilon, and others. The recommendations of the manufacturers and of the American Institute for Laundering for all of these call for low temperature, gentle washing – gentle not only in terms of mechanical agitation, but also in terms of the detergents and other washing materials used.

There seems to be no reason to believe that blankets made entirely, or in part, of synthetic fibers will be adversely affected by use of quaternary

[4]Walter, Carl W.: Aseptic Technic in the Postdoctorate Program. Hosp. Topics. 34:95 (April) 1956.

[5]Field, F. and Weil, T. P.: What You Can Do To Fight Staph Infection. Institutional Laundry 2:14 (July) 1958.

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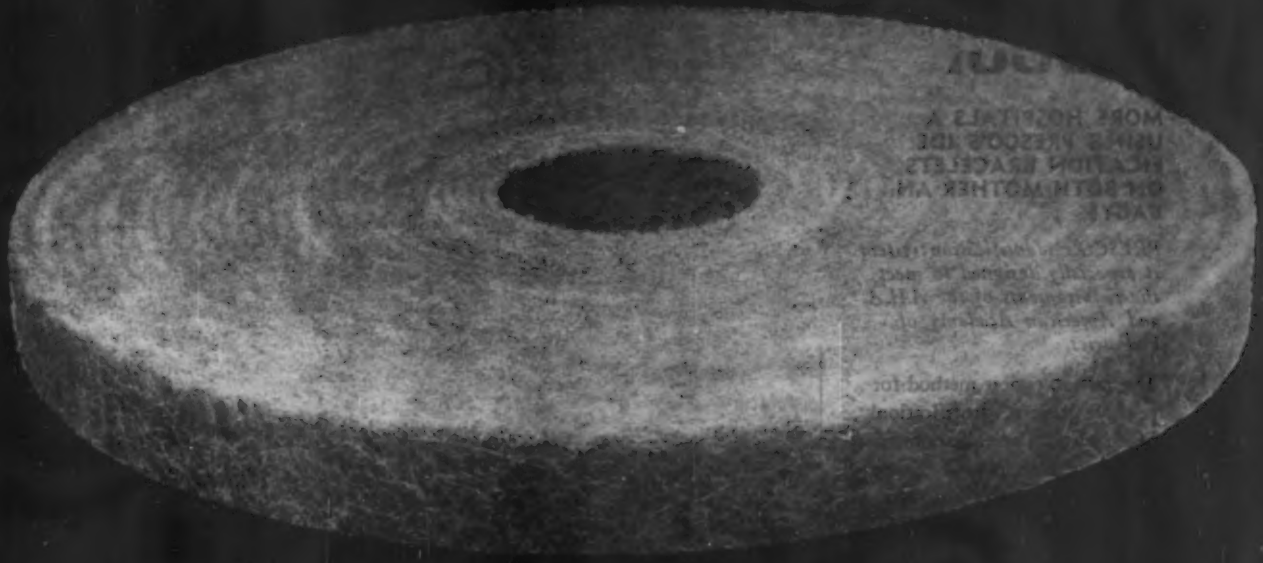

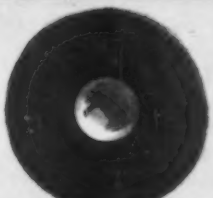

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ammonium or synthetic phenol disinfectants. This statement is subject to revision. At the moment, however, no reports have been found in the literature of difficulties that have been encountered.

Applies to Blankets

It seems reasonable, therefore, to apply the discussion in the previous section in toto to blankets containing synthetic fibers.

In the absence of data concerning depreciation of blankets of varying fiber compositions when subjected to repeated washing, accurate cost figures cannot be developed. A detailed study of the other costs in each hospital would be needed for an accurate total cost per blanket to wash and disinfect each blanket following the discharge of the patient.

Cotton. It appears that cotton blankets may be subjected to essentially the same washing technics as are used on other cotton goods. Technical Bulletin No. 10 issued by the American Institute of Laundering states:

"Cotton blankets containing no wool may be laundered in rib-types of washers, usually with a cotton fugitive formula. . . . It should be remembered that the contraction or shrinkage of cotton woven goods, unlike wool, is not affected by the washing process used. Furthermore, in contrast to wool, cotton does not develop increased shrinkages at temperatures above 100 F. Neither is the shrinkage of cotton woven fabric decreased by using high water levels in place of lower ones. In other words, a cotton blanket will contract approximately the same degree whether it is laundered by means of a cotton or wool formula."

Blowers et al. conducted a study to find a blanket material which could be easily and effectively sterilized.[6] They had concluded, prior to starting this study, that for reasons of simplicity, economy and bacteriological safety for the patient, it would be best if blankets could be sterilized by high-temperature washing. Two types of cotton blankets (loomstate cotton weave and turkish toweling), which had been laundered 20 times at 100 C. (273 F.) in 12 months of use, were reported as virtually unaltered in texture with not more than 5 per cent shrinkage in area.

Schwabacher and her fellow workers tested cellular cotton blankets that were washed at 100 C.[7] They reported observing no deterioration after 50 washings. They said that, ". . . these blankets shrank by about 10 per cent when they were washed, but this was found to be an advantage because the mesh became closer and the material was more pliable afterwards."

These studies showing that washing cotton blankets at 273 F. is not particularly damaging are of special significance in view of the fact that the typical recommended washing temperature for cotton is only 160 to 170 F.

Achieves Virtual Sterility

Studies have shown that the procedures followed in hospital laundries to make cottons clean generally make them virtually sterile. The various steps in the laundry routine reduce the bacteria count by removing the microorganisms physically and by destroying some of those that remain. Since the disinfectant effect of the total procedure depends on the particular combination of many factors, such as the washing temperature, bleaches and detergents used, no effort will be made here to describe a specific washing cycle which will produce the virtual sterility desired. The procedure to be followed should be based on published studies, on the equipment that is available in the hospital, and on the professional experience of the laundry manager. These, however, should be reinforced by periodic bacteriological studies of the finished product.

There are no data available that would allow the computation of the cost involved in a system based on the use of cotton blankets that are subjected to high temperature washing after each use. It is not known how rapidly various types and brands of cotton blankets would wear out if washed after each discharge; therefore, depreciation cannot be computed. It would be difficult to determine the additional expense involved in collecting blankets in addition to the other bedding from nursing units. The cost in the laundry can be considered to be the same, per pound, as the other cottons that are processed. ■

[6]Blowers, R.; Potter, J., and Wallace, K. R.: Clean Beds. Lancet 1:629 (March 23) 1957.

[7]Schwabacher, H.; Salsbury, A. J., and Fincham, W. J.: Blankets and Infection: Wool, Terylene or Cotton. Lancet 2:709 (Oct. 4) 1958.

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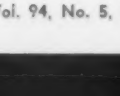
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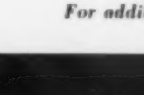
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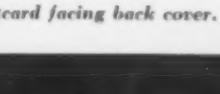
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NYLON CAM GRAVITY TYPE BOTTOM DOOR HINGE

Why Nurses Misuse — or Don't Use — Equipment

Unless nurses are given specific instructions on how to operate and care for new equipment, including new models with different features, it may end up on the shelf or in the repair shop, a nursing consultant advises

Alice L. Price, R.N.

MANY members of the hospital staff, such as nurses, are not as a rule mechanically minded. Therefore, they may be using equipment that they do not completely understand. Experience has shown that when such people do not understand the principles underlying the operation of complex equipment, they are likely to misuse or abuse it unknowingly.

Sometimes nurses, for example, encounter new equipment or new models of equipment without the benefit of an explanation of its purpose and features. Without understanding the basic differences between the new equipment and the old equipment or model it replaces, the nurse is expected to begin at once to use it correctly and effectively.

Need Education Program

In such cases, an educational program is needed so all hospital personnel can be informed, in detail, how to use equipment correctly.

The manufacturer, the hospital administrator, and often the hospital engineer should assume responsibility for making sure the new equipment is carefully explained to those who will use it. The manufacturer should furnish a booklet of instructions for the correct use of the article; the administrator should see that the booklet is made available to those who will use the equipment, and the engineer should explain any differences in the preventive maintenance required for the new item.

At present, a routine such as this is too often followed:

The sales representative describes the article of equipment to the administrator, members of the hospital board, the purchasing agent or the hospital engineer. The equipment is purchased and delivered to the hospital. Movers take the equipment directly to the department where it is to be used, install or place it in the designated unit.

A nurse, who has never seen the equipment before and has heard nothing about it, is expected to be able to put it into use immediately. Without instructions or directions she will tend to use the new article in exactly the same way as the item it replaces or which it most closely resembles.

On one of my hospital visits I talked with a head nurse who refused to use safety sides for the beds in her department. She told me she had asked for the long guards and that the supply service had sent the short safety sides instead. She further stated: "They're only half as long so they're only half as good."

No one had explained to her the theory behind the use of the short safety sides.

In criticizing the short side guard she had displayed the characteristic human reaction of being "agin" something that was unfamiliar to her.

Incorrect use of hospital equipment can waste time and materials. Just how wasteful is well illustrated by an incident that occurred in another hospital.

Results in Wasted Time

A doctor ordered one of his patients to be placed in shock position. An aide was sent to central supply for 18 inch shock blocks. Two orderlies and a nurse worked together to raise the foot end of the bed and place the shock blocks in position. That afternoon the doctor saw the patient and ordered a shock position that would be "less extreme." The aide was sent for 15 inch shock blocks. Central supply could find only one 15 inch shock block. The maintenance man was asked to make one 15 inch shock block. Using the one which was available as a pattern he made a second 15 inch shock block. It took two orderlies and a nurse to lift the bed and to remove the 18 inch shock blocks, then to place in position the 15 inch blocks. The bed they were lifting had a Trendelenburg spring

Miss Price is a nursing consultant, Batesville, Ind.

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which could be adjusted to any desired shock position by one nurse in about 30 seconds. The nurse did not know about the Trendelenburg spring and the ease with which it could be adjusted.

Bedside cabinets with reversible doors are also often misused for a similar reason. By reversing the door, the cabinet can be made to open from the right or the left side. In many hospitals, these cabinets are in use with the door opening from the wrong side, thus making them inconvenient for the patient – all because the nurses have not been informed of the simple procedure of reversing the door.

When a hospital administrator buys a new appliance for his home he expects to receive a booklet of instructions for the appliance and usually requires that the store arrange to demonstrate the article at his home. He will see that good care is taken of the equipment and will see that it is serviced as prescribed in the manual or booklet of instructions.

Yet that same man will buy hospital equipment that is highly complex, have it delivered to a nursing department and put into use there without arranging for a demonstration or for the instruction of nursing personnel who will have to use the new equipment.

Small Items Misused

Many small articles, as well as large, are incorrectly used in the hospital.

Wastebaskets are pushed under adjustable height beds when the beds are in high position. When the bed is lowered, the wastebasket is crushed.

Hot water bottles and rubber gloves are sent to the laundry with soiled linen and are completely ruined when they are placed in the hot water of the washer.

Thermometers can be broken by the dozen when a thoughtless or uninformed nurse holds a handful of them under running hot water to clean.

Hospital employes should know the cost of equipment they are handling in performing routine duties. If a nurse is informed that one stretcher cart costs approximately $700, she is likely to be impressed by that knowledge and therefore will be encouraged to learn the correct use of the article. ■

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Exhibits and Fairs Teach Employes To Make

L. M. Nolan

This San Francisco hospital held an exhibit to teach nurses—and invited the neighbors

NURSES had an opportunity to learn by doing — outside of the actual work situation — at an equipment workshop held at St. Francis Memorial Hospital, San Francisco.

With all the new equipment that is continually being developed and the advancements in nursing care, nursing employes may not have had the opportunity of learning the fine points of new equipment before they are called upon to use it. Recognition of this situation prompted the inservice education committee at St. Francis to sponsor the two-day exhibit.

Mrs. Nolan was chairman of the exhibit for the committee on inservice education at St. Francis Memorial Hospital, San Francisco.

New equipment being used at the hospital was demonstrated and nurses were given a chance to operate it.

New types of beds, patient lifters, an oscillating mattress, a new type of cardiograph machine, wheel chairs, intravenous setups, and traction equipment were exhibited. Oxygen therapy and various types of suction, including two-way underwater suction, were demonstrated along with the proper equipment.

In addition, members of the medical staff gave half-hour lectures on such subjects as orthopedic follow-through by nursing personnel, burn therapy, care of an infant following plastic surgery, and technics of rehabilitation.

Invitations were sent not only to the medical and nursing staffs at St. Francis, but also to directors of nursing of other hospitals, alumnae, nursing associations, department heads, and all nursing personnel.

A total of approximately 500 nurses and doctors attended, with representation from almost every hospital in San Francisco.

This exhibit workshop was covered by the various newspapers and films of it were shown over a local television station. ■

Above: Orderly demonstrates traction equipment for television cameraman, left, while head nurse, in back, talks with supply representative. In foreground, nurse examines newest incubator. In picture at right, head nurse learns about a new type of cardiograph.

the Most of New Equipment

Nona Pair, R.N.

New equipment and new methods stimulated employes' ideas at this Wyoming hospital fair

NEW equipment is wasted on employes unless they are taught to use it properly. If they follow old technics they may fail to make the most of the improvements of the new model, or the equipment may end up on the shelf with the complaint that "this new gadget just doesn't work."

How to instruct personnel in the use of new equipment is a problem, as individual instruction is usually too limited. **At Memorial Hospital of Natrona County, Casper, Wyo., we developed an approach that proved highly successful.**

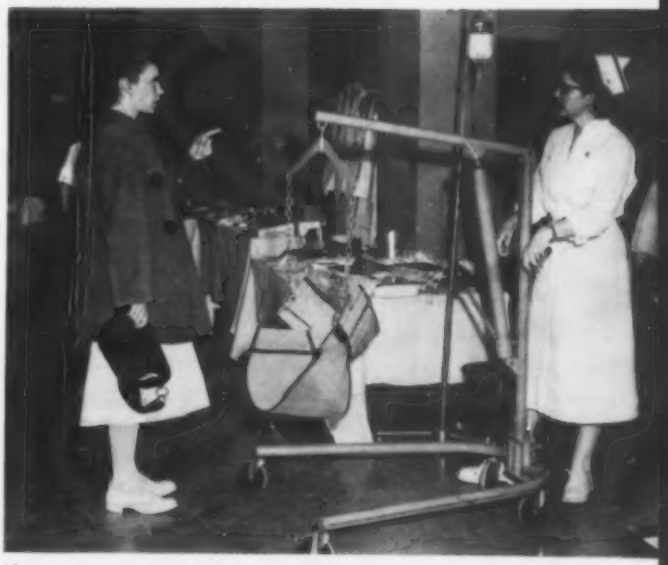
We had been demonstrating new equipment and procedures in our inservice educational meetings, but felt the demonstrations needed to be supplemented by a more general equipment and supply fair.

All important innovations in equipment and methods instituted during the last two years were included. Of special significance was a request to exhibit some of our innovations that had been most favorably received by the patients, "so everyone will know about them."

Several months prior to the fair we had established a patient unit pack system that provides newly admitted patients with a sealed package containing sterilized bath and emesis basins, facial tissues, soap, skin lotion, mouthwash and towels. Bedpans and urinals are packaged separately. This system was prominently displayed.

An unexpected dividend of the show was the number of new ideas presented by visitors. Comments made by a staff nurse, for example, resulted in changing the method of moistening hot packs, and a physician's suggestion regarding the contents of the tracheotomy care tray produced several changes in its make-up.

The enthusiastic response to this first show has prompted us to make it an annual affair, and in the meantime we plan a permanent display case to provide information on new supply and equipment items. ■



Above: Nurse demonstrates a hydraulic patient lifter and explains its operation to a visitor. Top: This extensive display of a new unit pack system proved of special interest to employes from all departments who welcomed chance to acquaint themselves with latest innovations.

Mrs. Pair is director of nursing service at Memorial Hospital of Natrona County, Casper, Wyo.

How Regulation Differs From Accreditation

(*Continued From Page* 114)

approved by the professional majority. A regulatory agency may not. Its rules have the force of law but they must remain within the framework of the law and cannot in any way go beyond it or conflict with it. It may not, through its rule making power, create an offense or outlaw an activity. It can only regulate what the legislature makes, or allows to remain, legal activity.

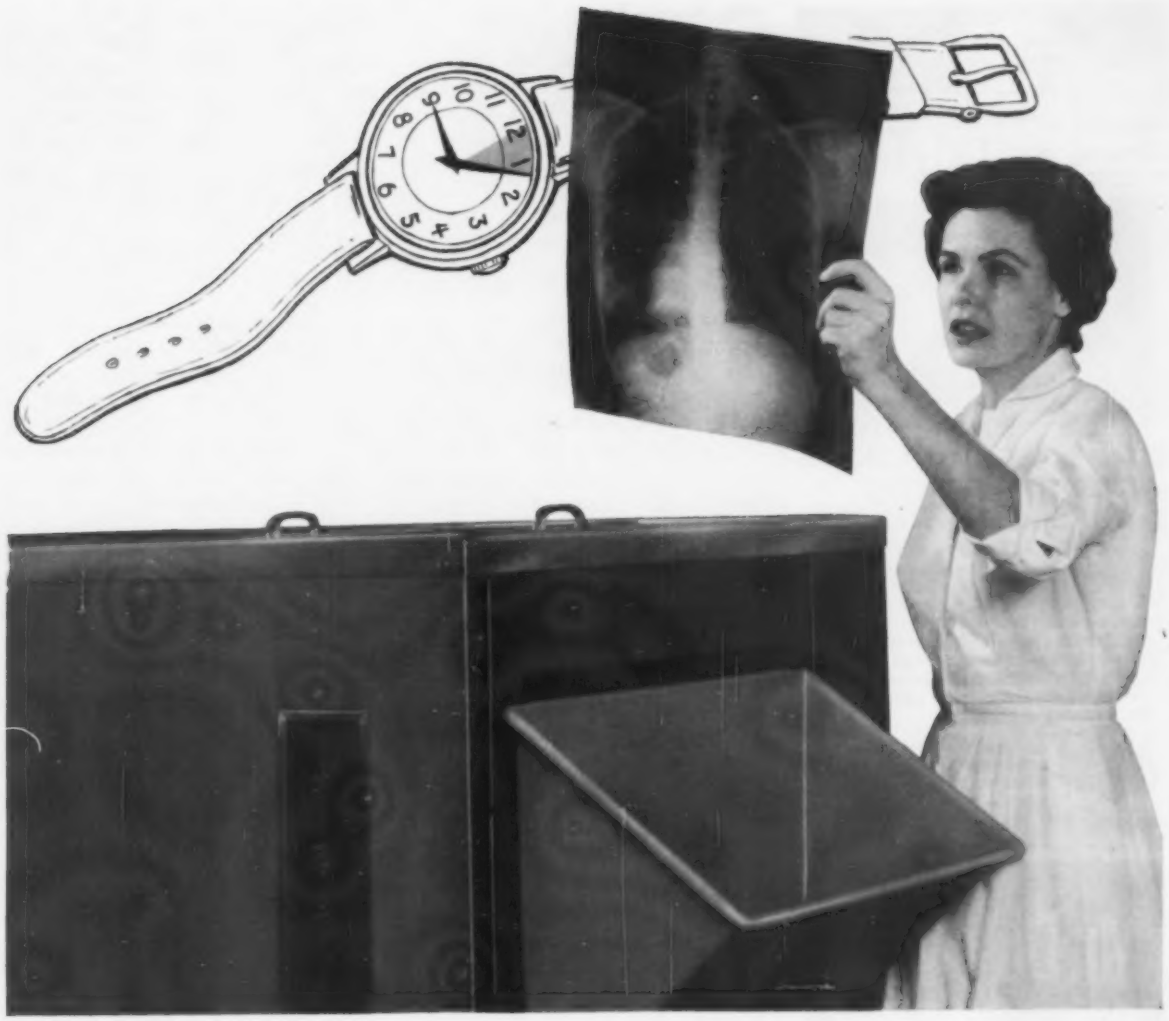
Governmental rules may not be confiscatory. They must take into consideration the property rights of those who might lose their investments or ability to earn a living if certain kinds of rules were enacted.

In its rule making and enforcement a regulatory agency must be constantly vigilant in order to maintain a balance between individual right and general welfare. On the one hand, general welfare may be endangered by permitting the existence of conditions which threaten the safety and well-being of those the law was designed to protect. On the other hand, the freedom of those seeking care or service may be invaded unnecessarily through restricting the individual's choice of the kind of living arrangement or medical service he will seek. The freedom of those wishing to engage in the regulated activity may also be violated by limiting unduly their opportunities to operate certain kinds of facilities, to experiment with new ideas, to compete financially with others in the field, to invest their money as they see fit or to practice philanthropy according to their own convictions. Determining the point at which individual right must yield before general welfare is the very essence of the regulatory responsibility. A voluntary accrediting agency may serve as champion of a cause which it believes will advance general welfare even though, if the cause is successful, individual freedom may be limited.

Control Specific Conditions

Finally, regulatory standards must be fitted to the particular situation with which they deal. Standards which describe what would be an ideal facility are useful as inspirations and guides to those who are attempting voluntarily to improve their practice. They are not useful in dealing with practical everyday situations that must be controlled if the public is to receive genuine protection. Terms like "model legislation" and "model regulatory standards" are self-contradictory since really good legal standards are those which help to control and improve conditions under very specific conditions. It is possible to list the elements of a good licensing law and good regulatory standards, but the most important of these elements is that both law and standards must be tailored to the needs and realities of the jurisdictional area.

Minimum standards should represent the very highest level of practice that the citizens of a state will support, and should be raised continuously as public understanding rises. But they must always be enforceable. The existence of regulatory legislation should be an assurance to every resident of a state that no matter in what county, rural or urban, or in what facility he seeks care, he will be protected by a legally guaranteed floor of safety and reliable service. ■



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Why Nurses Leave — and What To Do About It

(*Continued From Page* 120)

the amount of pressure on the individual nurse during her working day, as they determine the amount of work each will have to accomplish. As Table 4 shows, three out of four measures were related to voluntary turnover. Hospitals with high percentages of voluntary turnover had lower nurse-patient and total staff-patient ratios and higher daily occupancy rates. Average length of patient stay was not related to voluntary turnover.

The differences between the high and low hospitals on these measures were clear. For example, the average daily occupancy rates of all hospitals characterized as having low percentages of voluntary turnover were lower than were those of hospitals having higher percentages of voluntary turnover. Similarly, all hospitals in the low group had higher total staff-patient ratios and, for the most part, higher full-time nurse-patient ratios also. Thus the findings appear to indicate that the amount of pressure placed on the nurse is an important factor in voluntary turnover. They definitely suggest that a reduction of pressure on its nurses might decrease a hospital's voluntary turnover.

A similar relation between hospital quality and voluntary turnover was found. (See Table 4.) In terms of the measures used the data strongly suggest that hospitals with low percentages of voluntary turnover are of better quality than are those with high percentages. In every case, the autopsy rates of hospitals having low voluntary turnover were higher than those in hospitals with high percentages of voluntary turnover. The picture is similar with respect to the number of approvals. The number of facilities offered was not as clearly related, however.

It will be remembered that the reverse was found in the case of total turnover. There, high quality was associated with high turnover. Except in the case of the number of facilities offered, however, the relationship was not as strong as for voluntary turnover.

None of the other hospital characteristics were related to voluntary turnover. Although the means in Table 4 suggest that there is more voluntary turnover in larger hospitals than in smaller ones, an examination of the individual scores made these results questionable. While the largest hospital had the highest percentage of voluntary turnover, the hospital next in size had the lowest percentage, indicating no true relationship. Nor did the age of the hospital prove to be a factor here any more than it did in the case of total turnover.

It should be noted at this point that the failure of the foregoing relations to occur in the present sample does not preclude the presence of such relationships in another sample. In the first place we examined only six hospitals. In the second place, as the data indicate, the hospitals were relatively homogeneous with respect to some of these characteristics. A more diverse as well as a larger sample is needed before any final conclusion can be reached. Finally, more sensitive measures of these characteristics might uncover relationships that we missed.

What do the findings in this study mean to other hospitals? Let's consider those relating to pressure on the nurses first. The data here suggest that an increase in the nurse-patient ratio and, even more important, the total staff-patient ratio might help reduce the percentage of turnover that is voluntary. The fact that the relation between voluntary turnover and total staff-patient ratio is more striking should, if it holds up in future studies, be good news to the hospital administrator. It suggests that he may be able to reduce turnover among his nurses by augmenting the size of his total personnel with less skilled and more readily available workers.

Another pressure measure, the daily occupancy rate, was found related to the percentage of voluntary turnover. Hospitals with higher occupancy rates had larger voluntary percentages. Realistically speaking the hospital administrator cannot reduce his occupancy rate in the interest of cutting down on his nursing turnover. However, this is related to the findings on total staff-patient ratios. Hospitals with lower daily occupancy rates tended to have higher staff-patient ratios, although the relationship was not perfect. In the absence of the ability to control the daily occupancy rate, an increase in staff might help solve the problem by reducing work load throughout the hospital and decreasing the pressure felt by the personnel. ■

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This Salary Program Gives All Employes a Fair Share

(*Continued From Page* 92)

months, and another 5 per cent increase at 12 months, the cost to the hospital was around $40,000, which was an approximate increase in payroll amounting to 9 per cent. Since the first year and a half of this program it is rather difficult to ascertain just what the exact cost to the hospital has been. We have also incorporated numerous merit increases in many of the positions, and we have also had the usual amount of turnover that can be expected, even with the best type of wage and salary administration program.

We also felt that we needed to give some recognition to employes with notable service. Without this consideration, some employes with a long period of faithful service to the hospital would have been receiving the same rate of pay as were some relatively new employes in the same jobs. After careful study, we evolved a plan of effecting some wage and salary adjustments bringing employes beyond the established minimums of their respective salary grades. This plan was based on a 5 per cent increase above established minimum after six months of service, and another 5 per cent increase for those who had been employed 12 months or more.

We also recognized that an ideal program would be one in which every employe would be paid a rate consistent with his job performance and dependability — in other words, according to a system of merit rating. This we finally had to deem impossible to achieve at the beginning of the program, because of the cost involved. In addition to the budgetary consideration, we also needed time to develop the proper rating tools and technics and time to teach and train our supervisory personnel the effective and consistent use of a merit rating system. Though our program thus included some consideration for length of service, we felt that it was only a stop-gap measure, pending implementation of a merit rating program.

Fortunately, we also discovered that some of our salaries were not out of line to any appreciable extent. Moreover, some of the salary recommendations for particular jobs were far *below* what we were already paying the employes. In these cases no reduction was made, as we had promised originally. Some of these discrepancies were caused by the different rates paid to male and female employes for performing the same jobs.

In some instances we found that the minimum salary scale as presented meant almost exorbitant increases in salaries. In these cases we decided we would give approximately one-half the increase immediately and the second portion of it at the end of six months. This was done because we did not wish to draw the employes' attention to the fact that they had been underpaid for many years. We also had a strong feeling that no person should receive a 25 to 35 per cent increase in pay.

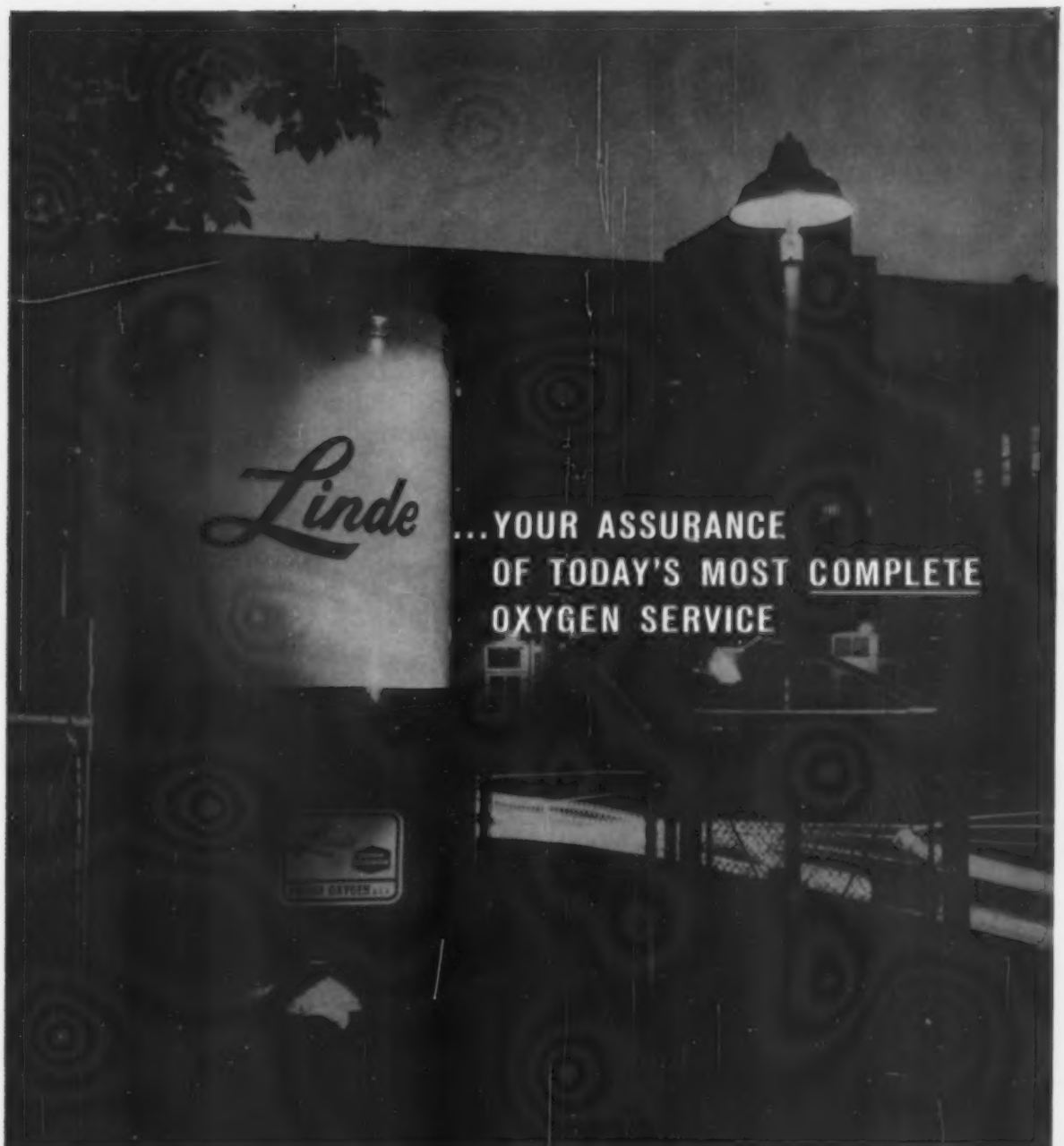
In several cases, after conferring with the departmental supervisor, we concluded that because of specific personality traits and ability the proposed salary was excessive, and we decided to reduce it slightly, pending improved attitude and production on the part of the individual concerned. We felt our program had to have this much flexibility.

Aside from providing a more equitable salary program, several other important benefits resulted. We now have job and personnel specifications for all positions in the hospital. These aid us appreciably in more effective personnel selection. Moreover, during the analysis of jobs we found that some of our jobs were not being performed properly. We now have a basis for correcting this situation, for we know what is being done and can make adjustments accordingly.

Not only have we worked out an equitable program of salaries for the various jobs within the hospital, but our wages and salaries are now more competitive in the community labor market, because of the external job-pricing phase of this study.

We do not claim that *all* of our personnel evils have been eliminated, but we are closer to resolving more of these problems than we were before. The salary schedules which were prepared and installed not only aided us materially in correcting pay inequities, but they gave us a basis for budgetary controls for planning.

We believe that all of the results achieved to date have been most beneficial, not only for our immediate need, but for the future as well. ■



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The Modern Hospital News Digest

A.H.A. President Supports Service Benefits for Federal Employes Under New Program

Hospital administrators should be able to provide "informed guidance" on health care programs to federal employes who are now in the process of choosing between service and indemnity benefits, emphasizes Dr. Russell A. Nelson, A.H.A. president, in a comparison of the differences between the available contracts.

(See page 96)

Blue Cross Plans Approve National Revision; Next Move Up to A.H.A. House of Delegates

A proposal for a new organization that will serve as "a single national voice for Blue Cross" was approved last month at the annual conference of U.S. and Canadian Blue Cross Plans.

(See page 179)

New York Hospital Accepts No-Strike Pledge in Contract Negotiations With Local 1199

Trafalgar Hospital and Local 1199 of the Drug and Hospital Employes Union have agreed to a perpetual no-strike pact in negotiations now under way, according to a report in the New York Times. The report said that both sides agreed to arbitrate all future conflicts including those that might develop over provisions to be included in subsequent contracts. Local 1199 is reportedly preparing a formal demand for recognition in 12 New York hospitals, including 7 hospitals at which it conducted a 46 day strike last spring.

(See earlier story on page 182)

New England Delegates Hear Speakers Criticize Hospitals' Shortcomings

BOSTON. – It was "Let's Beat Up on Hospitals" week in Boston when the New England Hospital Assembly met here March 28 to 30. And if the more than 6000 delegates to the meeting crept home feeling unloved and unappreciated, they could hardly be blamed.

Speaker after speaker chided the hospitals for a whole calendar of sins. The administrators were told, among other things, that:

1. Hospital staffs, both professional and nonprofessional, are cold and impersonal to the patients.
2. Hospital personnel policies are deplorable.
3. Hospital standards of cleanliness leave much to be desired, a major fault being the substitution of germicides for mechanical cleanliness.
4. Hospitals have failed signally to meet the challenge of the changing social and economic order of things.

These frank discussions of their shortcomings, however, didn't discourage the New England delegates a bit. They jammed all the meeting rooms and applauded their critics with enthusiasm. One man, who had tried unavailingly to pry his way into a session at which women's auxiliary members were gleefully satirizing women's auxiliaries, complained: "These programs are just too darned successful."

Leading the parade of critics at the Monday morning meeting, Dr. Charles L. Schepens, surgeon of Massachusetts Eye and Ear Hospital, stated that the art of healing has been totally lost in hospitals today. Hospital staffs are too cool, too impersonal, for the patients, he charged. "If we are going to get the patient well, we have got to get back to the art of healing, friendliness and an understanding of patient psychology."

Dr. Schepens' statements were echoed by the Rev. G. Douglas Krumbhaar, canon of St. Paul's Cathedral, Boston, who urged doctors to try to understand their patients' feelings a little better, and by Raymond P. Sloan, chairman of the editorial board of The MODERN HOSPITAL, who pointed out that the labor

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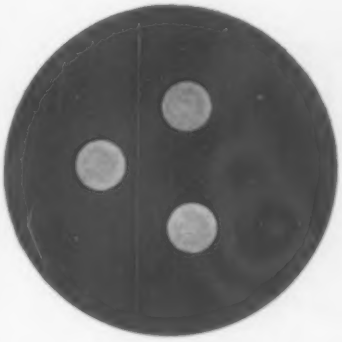

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debates that have occupied so many hospitals during recent months have served to demonstrate how deficient hospitals have been in their personnel policies.

In defense of the hospitals, Dr. Cecil G. Sheps, professor of medical hospital administration, University of Pittsburgh, stated that the loss of human touch is the result of a complex organization in today's hospitals. He explained: "You have a bureaucracy whether you like it or not. . . . Take a person entering a hospital with hemophilia today. In the first hour he is looked at by some 28 people."

High point of the three-day meeting, and of the criticism of hospitals, came at the Tuesday afternoon session on "The Voluntary Nonprofit Hospital's Future in Medical Care," under the chairmanship of Dr. Albert W. Snoke, director, Grace-New Haven Hospital, New Haven, Conn. Panelists at this meeting included Dr. Russell A. Nelson, president of the American Hospital Association and director of Johns Hopkins Hospital, Baltimore; Dr. Leonard W. Larson, chairman of the board of trustees of the American Medical Association; Hon. Elliott L. Richardson, United States attorney for the District of Massachusetts, and Nelson Cruikshank, director of the department of social security, A.F.L.-C.I.O., Washington, D.C. The presence of Dr. Larson and Mr. Cruikshank on the same platform drew newspaper reporters from miles around – looking for blood, and they were plainly disappointed when no blood flowed. Dr. Larson and Mr. Cruikshank have debated their widely opposing views on the Forand Bill, and other aspects of government intervention in medicine and hospitals, so often that they rather enjoy their "act" and make a great point of calling the audience's attention to the rare subjects on which they agree.

Only once did the discussion descend from a high-level exchange of views. That was when Mr. Cruikshank took an oblique swipe at Dr. Larson (a pathologist) with a reference to the "sacred pathologist-cadaver relationship," which brought a strangled snort from the audience, but which Dr. Larson ignored.

The burden of Mr. Cruikshank's complaint against voluntary hospitals is that hospitals have lost sight of their real purpose, which is to help the people of the community retain and regain their health.

"But as we survey today's hospital world, that purpose seems frequently to be regarded by the hospital as almost incidental," Mr. Cruikshank said. He charged that hospital boards of trustees "reflect the social organization of the last century," whereas the support of hospitals now comes from a host of small contributors and more importantly from prepayment health insurance of some kind or another. Mr. Cruikshank continued:

"Surely hospitals are not meeting their community responsibilities when, often without even a decorous scream, they watch the abduction of their radiology and pathology departments by predatory commercialists.

"When hospitals speak out against health benefits for old people through social security, whom are they speaking for? They do not speak for the people of their community. They do not even speak in the interest of their hospitals."

In no way moved by Mr. Cruikshank's arguments, Dr. Larson reiterated the A.M.A.'s position that the problem of health care for the aged

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is not as great as proponents of the Forand Bill think it it.

The greatest problem confronting the health field today, in Dr. Larson's view, is to improve communication between the professional staff, administration and boards of trustees, He added: "I believe the present voluntary hospital structure should provide the physician with direct participation in planning and organizing the hospital operation, since his own plans have a direct effect on the success of both plans and operation."

In the discussion following the formal presentation of papers, Mr. Richardson asked if the labor organizations would really like to see the system of financial benefits proposed under the Forand Bill extended to the population as a whole, and how it would be possible to hold the line against extension of health benefits to all segments of the public. "Won't the people who are paying for the health care of the aged want the same benefits for themselves?"

In replay, Mr. Cruikshank contended that if government takes away the high-risk cases through the social security mechanism, the pressure on Blue Cross and commercial insurance will be greatly relieved.

Summing up from the hospitals' point of view, Dr. Nelson stated that hospitals are "caught between the upper stone of the medical profession and the lower stone of the consumer."

New officers named at the New England Hospital Assembly meeting are: seated l. to r., treasurer, Pearl R. Fisher, R.N., Thayer Hospital, Waterville, Me.; president-elect, Elmina Snow, R.N., Emerson Hospital, Concord, Mass.; standing, president, Dr. Isidore S. Geetter, Mount Sinai Hospital, Hartford, Conn., and secretary, Horace Altman, Robert Breck Brigham Hospital, Boston.

Exhibitors Take the Prizes

During the New England Hospital Assembly, officials of the Hospital Industries Association presented awards for the best commercial exhibits, as shown in the accompanying photograph. From left to right: *Honorable Mention, Single Booth:* Harris L. Willets, president, C. R. Bard, Inc., Summit, N. J.; William E. Smith, executive secretary, Hospital Industries, Inc.; *First Prize, Single Booth:* H. J. Polk, Linde Co., New York; *First Prize, Multiple Booth:* Walter J. Cassady, Acme Visible Records, Crozet, Va.; Reo J. Marcotte, M.D., director, Mount Auburn Hospital, Cambridge, Mass., exhibit manager; *Honorable Mention, Multiple Booth:* Kenneth Hickman, Royal Metal Co., New York.

Plans Approve National Blue Cross Revision; Next Move Up to A.H.A. House of Delegates

LOS ANGELES. — National reorganization of Blue Cross came closer last month as the Blue Cross plans of the United States and Canada voted at their annual conference to establish a single national group to succeed the Blue Cross Commission and the Blue Cross Association.

The new organization, which will represent Blue Cross nationally and in Canada, will operate under the corporate structure of the Blue Cross Association. (Details of the revision were described in The MODERN HOSPITAL, March 1960, *p.* 74.)

Last parliamentary hurdle for the new agency is expected to be easily cleared at the American Hospital Association meeting in San Francisco August 29, when the A.H.A. House of Delegates will vote on by-law revisions needed to implement the change.

In a joint statement, signed by Dr. Russell A. Nelson, A.H.A. president, James E. Stuart, president, Blue Cross Association, and H. Charles Abbott, chairman of the Blue Cross Commission, hope was expressed "that the new national Blue Cross structure will add to the dispatch, economy and efficiency with which national accounts are served, whether uniform national benefits or local benefits are desired.

C. Rufus Rorem (center) receives the Justin Ford Kimball award from Mr. Abbott (left) and Dr. Nelson (right) for his contributions to the principle of prepaid health care.

"We expect," the statement continued, "that the new organization

will provide a channel for easier and more frequent communication between Blue Cross plans, further uniting them in the implementation of better benefits and community programs that are in pace with the growing needs of the American people. A single national voice for Blue Cross, we believe, will facilitate the educational process by which Blue Cross and the national public influence each other."

Earlier, a Detroit department store executive speaking at the conference had accused some Blue Cross leaders of abandoning their basic principles and "trying to meet the competition on their own ground and with the weapons of their choosing — tossing aside community rating to try to experience rate; ditching, or at least diluting, 'service benefits' for cash indemnity."

The speaker, John W. Paynter, said that some compromises may be necessary, but they should be "in the real area of progressive compromise — the area of national uniformity of benefits and availability.

Although the lagging growth of Blue Cross has been the cause of some concern and many public statements by both hospital and prepayment officials, last year's Blue Cross annual report disclosed that more than one million new members were added in 1959, bringing the total number of Blue Cross memberships to 56,962,955.

The plans' financial statement also took a decided turn for the better. In 1959 Blue Cross had to take $40 million from reserves. Last year, however, the report showed that the plans were able to return $20 million to reserve funds.

The collective hospital bill of Blue Cross members paid last year totaled a whopping $1,469,601,588, according to the report. This is a record Blue Cross payment to hospitals for care of members and is an increase of more than $1 million from what hospitals received through Blue Cross in 1958. Average length of stay for Blue Cross patients during 1959 was 7.6 days, the report disclosed.

New York Blue Cross Plan Elects J. Douglas Colman

NEW YORK. — J. Douglas Colman has been elected president of Associated Hospital Service, Inc., the largest Blue Cross plan in the country.

J. D. Colman

David Brumbaugh, who announced the appointment, which was effective May 1, had served as interim chief executive officer of the plan. He will continue to serve as board chairman.

Mr. Colman had been vice president and secretary of the national Blue Cross Association since 1957. During that time he developed a program of health benefits for federal employes and their dependents, which was recently adopted by the federal government.

Previously, Mr. Colman had been vice president of Johns Hopkins University and Johns Hopkins Hospital. Prior to that for 14 years he had served concurrently as director of Maryland Hospital Service Plan (Blue Cross) and Maryland Medical Service (Blue Shield). Since 1957 he has been treasurer of the National Tuberculosis Association.

New York Drug Union Signs Two Hospitals; Signals First Break in Nonrecognition Pact

NEW YORK. — Bargaining recognition has been granted a hospital workers union by two member hospitals of the Greater New York Hospital Association.

Leon J. Davis, president of the union, Local 1199 of the Drug and Hospital Employes, announced that the hospitals are the Home and Hospital of the Daughters of Israel in Manhattan and the Home and Hospital of the Daughters of Jacob in the Bronx.

The announcement came after nonprofessional, technical and office employes at Trafalgar Hospital here, which is not a member of the association, voted to be represented by the union, according to a New York Times report.

The two hospitals that recognized the union earlier are among 37 nonprofit institutions that signed a statement of policy to end a 46 day strike last year against seven association hospitals.

Under the statement, the institutions would unilaterally set wages, hours and working conditions without recognizing the union.

Recognition by the two hospitals is the first break since the strike with the hospitals' position that they are exempt from state and federal union recognition laws because of their nonprofit nature, the Times noted.

The union also has contracts with two other voluntary hospitals that are members of the association. However, these hospitals, Montefiore and Maimonides, had signed pacts before the strike.

New York Union Lists Nursing Home Demands

NEW YORK. — Nursing homes in this area have been warned that Building Service Employes Local 144, will not settle an industry agreement this year unless it provides for a five-day week.

The current contract with the union covers an estimated 2500 employes, according to a Services Labor Report published by the Bureau of National Affairs, Inc. The report said the union claims to have signed more than 200 establishments in 1957.

Demands for this year's contract include: five-day week with a seven-hour day; $1.50 an hour minimum pay and time and a half overtime pay after seven hours; time and a quarter pay for part-time workers; severance pay when operation ends; eight days of paid sick leave and 11 paid holidays plus the worker's birthday; classification for all categories; uniforms furnished and maintained by employer; family medical coverage; one week vacation after six months, two weeks after one year, and three weeks after two years.

Economics Behind Union Drive, A.H.A. Official Tells New Hampshire Group

CONCORD, N.H. — Powerful economic incentives are behind union drives to organize hospitals, the New Hampshire Hospital Association was told here recently.

Jack W. Owen, secretary of the committee on personnel administration of the American Hospital Association, suggested some reasons.

"There are some 853,000 nonprofessional workers in our hospitals. Of

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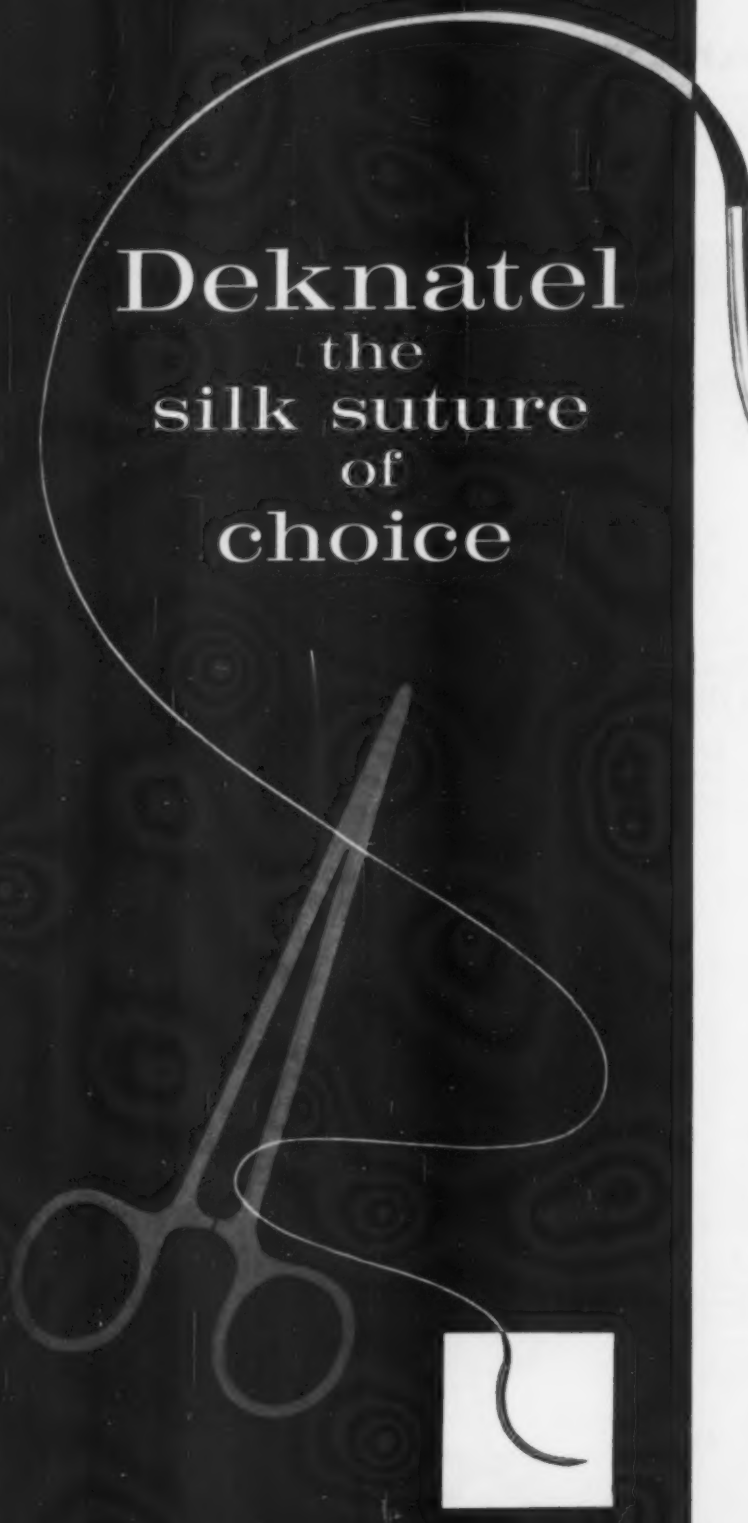

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this amount, there are approximately 20,000 who are unionized," he said. "If the remaining 833,000 could be unionized and would pay a minimum of probably $3 a month in dues, it would mean $2,499,000 a month for the organizers," he explained.

Union officials, he added, are on record as stating that membership drives will be made for white collar workers because organized labor has pretty well saturated industry.

Mr. Owen said union attempts to organize the hospital field are made primarily by small locals. He pointed out that there is a concerted effort to get union membership on hospital boards where pressure can be exerted to sign a contract. He said unions will threaten not to contribute to fund raising or make donations if hospitals refuse to bargain.

Organizers use political influence, enlist support of priests, rabbis and ministers, and put pressure on suppliers, Mr. Owen said.

"The weapon of the organizer," he said, "is fear. If he can panic the administrator, half his battle is won. His plan is to stir up action, indiscriminate firing, statements in the paper. The union is seeking security, recognition and self-expression for itself and its members, and it wants these objectives written out in the form of a contract.

New officers of the Ohio Hospital Association are (l. to r.): district chairman, Sister Eugene Marie, Good Samaritan Hospital, Cincinnati; district chairman, James E. Moss, Riverside Hospital, Toledo; president, John Gettman, Memorial Hospital, Fremont; vice president, Edgar Mansfield, White Cross Hospital, Columbus, and the president-elect for 1961, Harold A. Zealley, Elyria Memorial Hospital, Elyria.

Sixteen Faculty Specialists To Study Hospital Planning at University of Michigan

ANN ARBOR, MICH. — Sixteen specialists in fields ranging from dietetics to structural design have assembled here to plan the future development of University of Michigan Hospital.

Consultants were drawn from schools and colleges of the University of Michigan and include representatives of the college of architecture and design, school of business, college of engineering, school of nursing, medical school, and the school of public health.

It is hoped that new concepts in hospital construction and operation may result from the unique group, according to Minor Vandermade, assistant director of the 1050 bed hospital, who organized the study.

Among the problems considered at the first meeting, held last month, was that of esthetics. The consultants will also tackle the conventional problems of making maximum use of space, and creating proper conditions for optimum working efficiency.

"To restore the dignity of the patient" is another goal. The specialists will seek ways to give patients the privacy of individual rooms, while allowing ample opportunities for sociability, and, at the same time, keeping costs down.

The group will also study new and different building materials for possible use in hospital construction.

Council and Association Merge in Philadelphia

PHILADELPHIA. — Merger of the Hospital Council of Philadelphia with the Philadelphia Hospital Association into an enlarged organization to be known as the Delaware Valley Hospital Council was approved last month.

Approval by the membership of the Hospital Council of Philadelphia, which made the announcement, was the final step in the merger that had been under consideration since the summer of 1959.

Membership in the new council may be granted to any hospital in the metropolitan Philadelphia area which meets such standards and requirements as may be prescribed by the board of directors.

An initial nominating committee for the new board of directors will be jointly appointed by Clarence A. Warden Jr., chairman of the former Hospital Council of Philadelphia, and H. Robert Cathcart, president of the former Philadelphia Hospital Association.

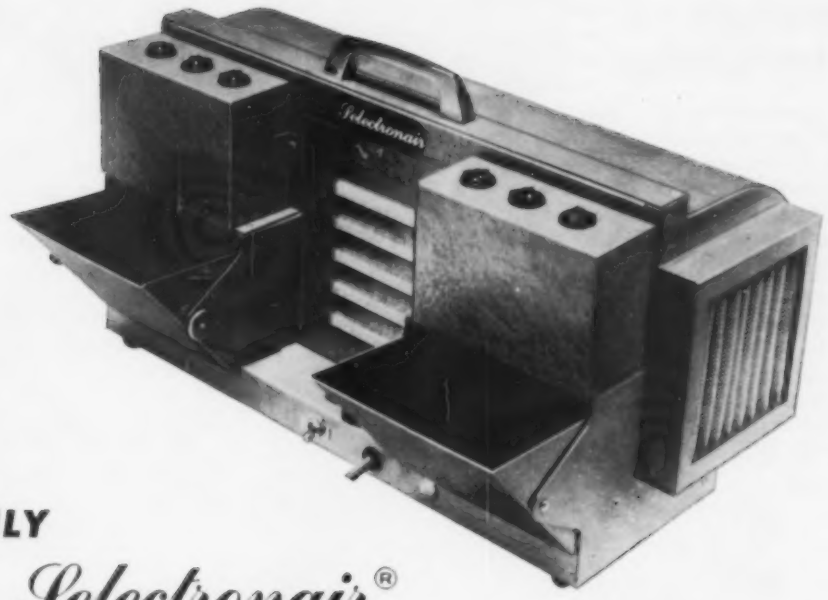
Employe Demands Blamed as Administrator Resigns

JASPER, ALA. — Employe demands have led to the resignation of the administrator and six board members at Jasper Community Hospital here, according to an Associated Press report.

Bob Bruner, administrator of the hospital, was quoted as saying he quit after a delegation of hospital employes demanded that he be fired.

The six board members reportedly resigned following a meeting of a group of hospital employes with a committee from the board.

"The employes refused to deal with me," Mr. Bruner said, "and wanted to deal directly with the board." He said the employes never approached him with their complaints, the press story added.



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Gap Closing Between A.H.A. and Nursing Groups, Frank Groner Tells Georgia Meeting

JEKYLL ISLAND, GA. — That yawning abyss between the American Hospital Association and national nursing organizations is narrowing, according to Frank S. Groner, A.H.A. president-elect.

Speaking at the annual meeting of the Georgia Hospital Association held here last month, Mr. Groner said that he is "hopeful of eventual agreement" with national nursing groups on nursing school accreditation although "the American Hospital Association is insisting that hospitals operating regular diploma schools of nursing have more voice in the nursing accreditation program."

General hospitals should not establish detention units for mental cases awaiting transfer to mental institutions, Whitelaw H. Hunt told his audience at the meeting. "However," he added, "if qualified psychiatrists are available, neuropsychiatric patients should be admitted to a general hospital."

Mr. Hunt, director of University Hospital, Augusta, described the hospital's neuropsychiatric unit where, he said, average length of stay was 10.5 days and direct cost per patient day for patients in the unit was $11.95.

Roger Klein, director of the graduate program in hospital administration at Emory University, outlined areas in which hospitals of the future should show improvement.

New officers of the Georgia Hospital Association elected at the meeting included president-elect, Arthur T. Stewart Jr., administrator of Minnie G. Boswell Memorial Hospital, Greensboro, and treasurer, Thomas B. Wolfe Jr., administrator of Polk General Hospital, Cedartown.

George E. Linney, administrator of Griffin-Spalding County Hospital, Griffin, will take office as president of the association.

Oliver G. Pratt Given A.H.A. Service Award

BOSTON. — During the New England Hospital Assembly's annual meeting here, Oliver G. Pratt, executive director of Rhode Island Hospital, Providence, R.I., was named to receive the American Hospital Association's Distinguished Service Award for 1960.

The Distinguished Service Award, the highest honor bestowed by the A.H.A., is conferred for outstanding leadership in hospital administration. Mr. Pratt is the 25th person to receive the award and its accompanying citation; they will be presented to him during the A.H.A.'s 62d annual meeting August 29 to September 1 in San Francisco.

Recipients of honorary membership in the A.H.A. announced at the meeting were: Ralph W. Berger, New York, president of the Hartford Foundation; Romain De Cock, M.D., Brussels, Belgium, president of the International Hospital Federation; Fred C. Foy, Pittsburgh, president of the Koppers Company, Inc., and chairman of the National League of Nursing's Committee on Careers in Nursing; Mrs. Abraham R. Pinanski, Brookline, Mass., a leader in the field of hospital auxiliaries, and Raymond P. Sloan, New York, chairman of the editorial board of The MODERN HOSPITAL.

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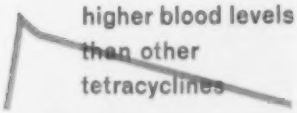

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COMING EVENTS

AMERICAN ASSOCIATION OF BLOOD BANKS, Jack Tar Hotel, San Francisco, Aug. 21-26.

AMERICAN ASSOCIATION FOR HOSPITAL CONSULTANTS, Fairmont Hotel, San Francisco, Aug. 27.

AMERICAN ASSOCIATION FOR HOSPITAL PLANNING, Federal Building and Clift Hotel, San Francisco, Aug. 26, 27.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Olympia Hotel, Seattle, Oct. 10-13.

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, Civic Auditorium and Sheraton-Palace, San Francisco, Aug. 29-Sept. 1.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Annual Convocation, Civic Auditorium and Jack Tar Hotel, San Francisco, Aug. 27-29.

AMERICAN COLLEGE OF OSTEOPATHIC HOSPITAL ADMINISTRATORS, Statler-Hilton Hotel, Dallas, Oct. 30.

AMERICAN COLLEGE OF SURGEONS, Clinical Congress, San Francisco, Oct. 10-14.

AMERICAN HOSPITAL ASSOCIATION, San Francisco, Aug. 29-Sept. 1.

AMERICAN MEDICAL ASSOCIATION, Miami Beach Hotel, Miami Beach, June 13-17.

AMERICAN NATIONAL RED CROSS, Kansas City, Mo., May 16-18.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, Statler-Hilton Hotel, Dallas, Oct. 31-Nov. 3.

AMERICAN PHARMACEUTICAL ASSOCIATION, Shoreham and Sheraton-Park Hotels, Washington, D.C., Aug. 14-19.

AMERICAN PHYSICAL THERAPY ASSOCIATION, Penn-Sheraton Hotel, Pittsburgh, June 26-July 2.

AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS, Palmer House, Chicago, Sept. 27-30.

AMERICAN SOCIETY OF HOSPITAL PHARMACISTS, Shoreham and Sheraton-Park Hotels, Washington, D.C., Aug. 14-19.

AMERICAN SOCIETY OF MEDICAL TECHNOLOGISTS, Hotel Ambassador, Atlantic City, June 19-24.

AMERICAN SOCIETY OF X-RAY TECHNICIANS, Netherland-Hilton Hotel, Cincinnati, June 11-16.

CATHOLIC HOSPITAL ASSOCIATION, Municipal Auditorium, Milwaukee, May 30-June 2.

COLORADO HOSPITAL ASSOCIATION, Stanley Hotel, Estes Park, Sept. 18-20.

COMITE DES HOSPITAUX DU QUEBEC, Show Mart, Montreal, June 25, 26.

(*Continued on Page* 192)

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CONNECTICUT HOSPITAL ASSOCIATION, Connecticut Light and Power Company, Berlin, June 8.

IDAHO HOSPITAL ASSOCIATION, Elk's Lodge, Boise, Oct. 17, 18.

KANSAS HOSPITAL ASSOCIATION, Broadview Hotel, Wichita, Nov. 10, 11.

MAINE HOSPITAL ASSOCIATION, Samoset Hotel, Rockland, June 7, 8.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Shoreham Hotel, Washington, D.C., Oct. 12-14.

MICHIGAN HOSPITAL ASSOCIATION, Park Palace Hotel, Traverse City, June 19-21.

MISSISSIPPI HOSPITAL ASSOCIATION, Hotel Buena Vista, Biloxi, June 20-22.

MISSOURI HOSPITAL ASSOCIATION, Hotel President, Kansas City, Nov. 16-18.

MONTANA HOSPITAL ASSOCIATION, Florence Hotel, Missoula, Sept. 12, 13.

NATIONAL ASSOCIATION OF BOARDS OF PHARMACY, Shoreham and Sheraton-Park Hotels, Washington, D.C., Sept. 15-19.

NATIONAL EXECUTIVE HOUSEKEEPERS ASSOCIATION CONGRESS, Mark Hopkins Hotel, San Francisco, June 1-4.

NORTH CAROLINA HOSPITAL ASSOCIATION, Fort Bragg, June 8-10.

OREGON ASSOCIATION OF HOSPITALS, Gearhart Hotel, Gearhart, Oct. 16-18.

RHODE ISLAND HOSPITAL ASSOCIATION, Sheraton-Biltmore Hotel, Providence, Oct. 4.

SASKATCHEWAN HOSPITAL ASSOCIATION, Beesborough Hotel, Saskatoon, Oct. 12-14.

TENNESSEE HOSPITAL ASSOCIATION, Peabody Hotel, Memphis, May 26, 27.

UPPER MIDWEST HOSPITAL CONFERENCE, Minneapolis Auditorium, Minneapolis, May 11-13.

WEST VIRGINIA HOSPITAL ASSOCIATION, White Sulphur Springs, Sept. 22-24.

Personnel Policies Major Topic at Hospital Institute

NEW YORK.—Personnel policies and procedures occupied a major share of the attention of members of the Northeastern New York Hospital Association at their biannual institute held here.

Talks on this subject made by Malcolm Shaw, visiting professor, and Harlan B. Perrins, associate professor, New York State School of Industrial and Labor Relations, Cornell University, were followed by a session on collective bargaining and the application of federal and state laws and court decisions to unionization of hospitals.

Hire Fewer, But Better Workers, I.H.A. Advises

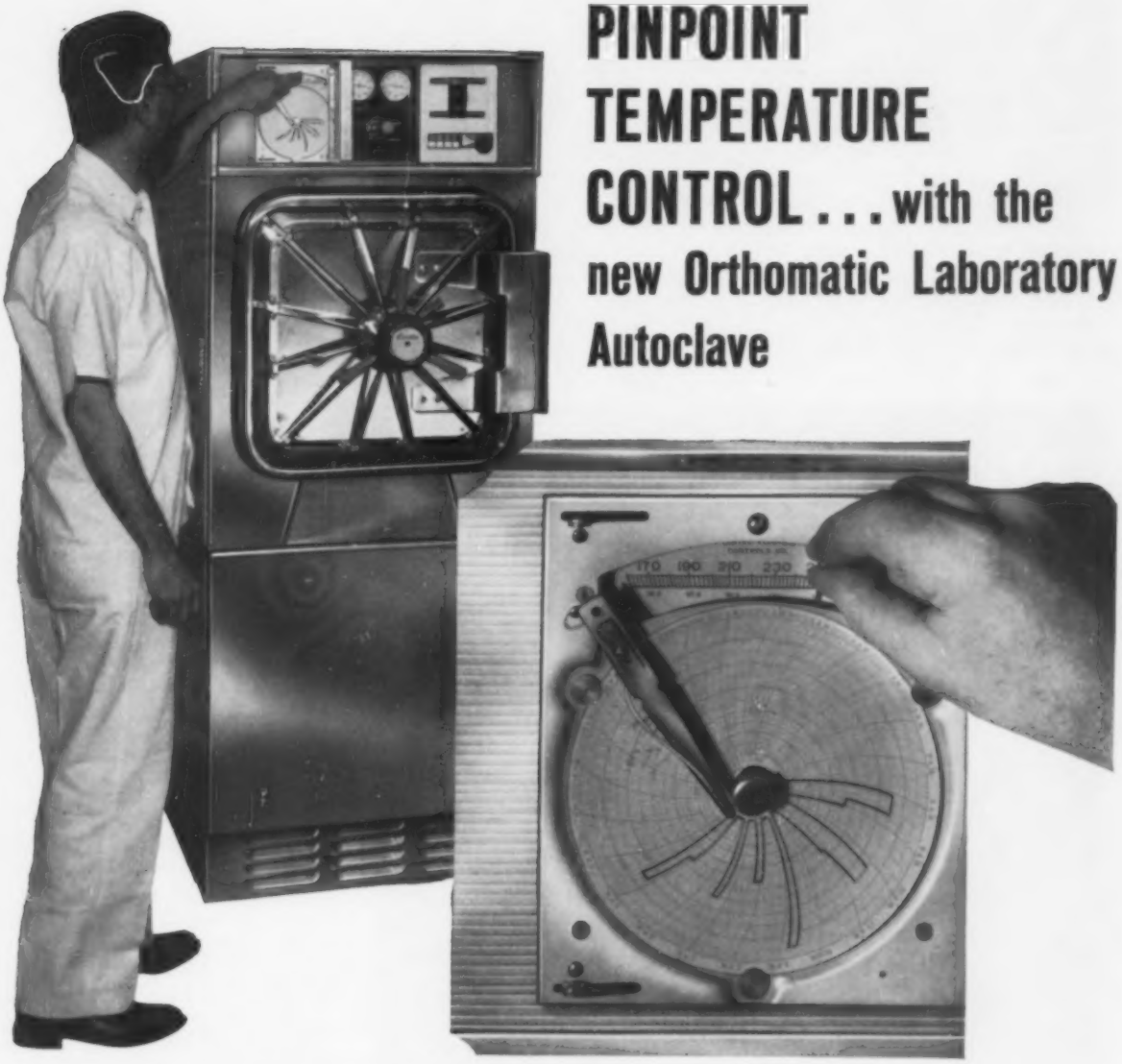
CHICAGO. — Hold down hospital bills by hiring fewer but better workers, the Illinois Hospital Association advised personnel directors last month.

In a series of five institutes, the I.H.A. stressed a new program to create "an improved climate of employment by the introduction into hospital management of more economical and more modern personnel procedures."

"Low grade work, high personnel turnover, and an excess of inefficient people on the payroll plague many hospitals," Delbert L. Price, president of the association, explained.

More modern personnel procedures, he said, should enable hospitals to employ better people "whose superior work performance will allow our hospitals to hold down payroll costs even though higher wages may be paid."

Total payroll expenses in all Illinois hospitals was more than $294.5 million in 1958, the state association disclosed, which is 64.2 per cent of the total hospital operating budget for that year.



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ABOUT PEOPLE

(*Continued From Page* 115)

Michael's Hospital, Newark, N.J., succeeding **Mother M. Bathildis,** who recently was elected Provincial Superior of the Eastern Province of the Franciscan Sister of the Poor. Sister Felicitas was former administrator of Margaret Mary Hospital, Batesville, Ind.

Sister Marie de Pazzi has been named administrator of Sacred Heart General Hospital, Eugene, Ore.

Silvio R. Lamattina has resigned as acting administrator of North Country Hospitals Inc., Gouverneur, N. Y., and has been appointed administrator of Monsour Hospital and Clinic, Jeanette, Pa. Mr. Lamattina was graduated from New York University and the Canadian Hospital Association's two-year course in hospital organization and management.

Chesney Malone has been appointed administrator of Orange County Hospital, Paoli, Ind., succeeding **W. A. Stewart,** who recently resigned.

Paul F. Detrick has been appointed administrator of Christian Hospital, St. Louis. Mr. Detrick has been administrator of Freeman Hospital, Joplin, Mo., and administrator of Memorial Hospital, Arkansas City, Kan. He graduated from Kansas State Teachers College and received his master of science degree in hospital administration from Northwestern University. Mr. Detrick is a member of the American College of Hospital Administrators and the Missouri Hospital Association.

P. F. Detrick

James Rutledge, former assistant to the administrator of Jasper Community Hospital, Jasper, Ala., has been named acting administrator following the resignation of **Bob Bruner.**

Clayton E. Alexander has been named administrator of Askew Memorial Hospital, Nashville, Ga. Mr. Alexander completed the course in hospital administration at Georgia State College and recently completed his administrative residency at Athens General Hospital, Athens, Ga.

Harold G. Michaels, former assistant to the director of the University of Maryland Hospital, Baltimore, has become administrative assistant at Grady Hospital, Atlanta. Mr. Michaels attended Johns Hopkins University and received his master's degree in hospital administration from the University of Pittsburgh.

Robert J. Marsh has been named administrative assistant of Chicago Wesley Memorial Hospital, Chicago. Mr. Marsh is a former administrator of the Staats Hospital and Clinic in Charleston, W. Va., and an organizer and director of the Blue Cross-Blue Shield in Huntington, W. Va. He joined Wesley Memorial Hospital as supervisor of medical services and currently is completing work on his master's degree in hospital administration at Northwestern University.

R. J. Marsh

Genevieve Smith, R.N., has been appointed superintendent of Harvey E. Rinehart Memorial Hospital, Wheeler, Ore. (*Cont. on p.* 196)

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Dr. Charles H. Jones has been named new superintendent of Butler Health Center, Providence, R.I. Dr. Jones was former superintendent of Northern State Hospital at Sedro Woolley, Wash. **Dr. J. Sanbourne Bockoven,** clinical director and acting superintendent of Butler Health Center, has resigned to accept the post of superintendent of Cushing State Hospital, Framingham, Mass.

Leon Gordon has been appointed administrator at McCurtain County Hospital, Idabel, Okla. Mr. Gordon succeeds **Mrs. Glen Housholder** who recently resigned to become administrator at Wetumka Hospital, Wetumka, Okla., which will soon be opened. Mr. Gordon was formerly administrator at Okfuskee Memorial Hospital, Okemah, Okla., where **Keith Calvert** has been appointed administrator.

Talton L. Francis, former administrator at Beauregard Memorial Baptist Hospital, DeRidder, La., has become administrator of Parkview Hospital, Yuma, Ariz. **Edward Massey,** business manager, will be acting administrator at Beauregard Memorial Hospital.

Leo Reich has succeeded **Elizabeth Parker** as administrator of Broadlawns General Hospital, Des Moines, Iowa.

William L. Fender Jr. has become administrator of Floyd County Memorial Hospital, New Albany, Ind., succeeding **Sam White** who served there for three years. Mr. Fender received his B.S. degree in business administration and his M.S. degree in hospital administration from Northwestern University.

Dr. Howard Hicks Ashbury assumed his duties as superintendent of Eastern State Hospital, Williamsburg, Va., succeeding **Dr. Joseph E. Barrett** who resigned last October to accept a position at Eastern State Hospital, Knoxville, Tenn. **Dr. James B. Funkhouser,** assistant commissioner of the Virginia Department of Mental Hygiene and Hospitals, was acting superintendent of Eastern State Hospital. Dr. Ashbury is a radiologist and taught neurology and psychiatry at University of Virginia Medical School. Later he was clinical director at Western State Hospital, Staunton, Va.

Norman R. Kiker has been appointed administrator of Coke County Memorial Hospital, Robert Lee, Tex. **Kenneth Bradberry,** former administrator, resigned to join the internal revenue service. (*Cont. on Page* 198)

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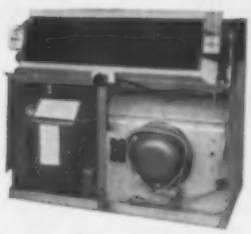

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CAMDEN 5, NEW JERSEY

R. J. Molgard has been appointed administrator of Five Counties Hospital, Lemmon, S.D., succeeding **James C. Smith.**

Dr. Robert E. Ashley has been named acting superintendent of Griffin Memorial Hospital, Norman, Okla. His predecessor, **Dr. Harry G. Hightower,** is going into private practice. The new superintendent has been acting clinical director since December, succeeding **Dr. Stanley Kemler,** who also resigned to enter private practice.

R. H. Hutto has resigned as administrator of Wayne General Hospital, Waynesboro, Miss. His successor is **James M. Stewart,** a graduate of the course in hospital administration at Georgia State College of Business. Mr. Stewart is a registered x-ray technician.

Dr. R. C. Eaton has been appointed superintendent of South Florida State Hospital, Hollywood. The hospital has also announced appointment of **Howard S. Sexsmith** as clinical director.

John M. Vickrey, special assistant to the manager of Veterans Administration Hospital, Salt Lake City, for the last five years, has been assigned as assistant manager of the V.A. center at Whipple, Ariz.

Jack Tindle Jr. has been named administrator of the new Community Hospital, Sweet Springs, Mo. For the last two years he had been business manager at Bothwell Memorial Hospital, Sedalia, Mo.

Frederic C. Hillis has been appointed administrator of Athol Memorial Hospital, Athol, Mass. Mr. Hillis, administrator of Delaware Valley Hospital, Walton, N.Y., since 1954, succeeds **John R. Lalley.**

Sam Johnson, former administrator of LeFlore County Memorial Hospital, Poteau, Okla., has become administrator of Henderson County Memorial Hospital, Athens, Tex.

Corrine Parke, administrator of Deuel County Memorial Hospital, Clear Lake, S.D., has resigned.

A. H. Jeffers, former administrator of Bacon County Hospital, Alma, Ga., has been appointed administrator of Lawrence County General Hospital, Lawrenceburg, Tenn.

Joseph A. Rainville has been appointed administrator of West Side Hospital, Scranton, Pa. Mr. Rainville has been associated with the administration of Northeastern Hospital, Philadelphia, and Physicians and Surgeons Hospital, Inc., Burlington, N.J. (*Cont. on Page* 200)

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Department Heads

Sandy Mannino, R.N., has been named director of nursing at Institute of Pennsylvania Hospital, Philadelphia. Mr. Mannino is a graduate of the Pennsylvania Hospital School of Nursing and received his B.S. and M.S. degrees from the University of Pennsylvania. Mr. Mannino was also science instructor at Pennsylvania Hospital School of Nursing for Men and the hospital's assistant director of nursing before his recent promotion. Mr. Mannino is a member of the American Nurses Association and the National League for Nursing.

Dr. Mark Imberman has been appointed acting chief of the Medical I Clinic of Mount Sinai Hospital, New York. Dr. Imberman has been associated with the diagnostic and sarcoidosis clinics of the hospital for the last 20 years and succeeds **Dr. Benjamin Eliasoph,** who recently retired. The hospital also announced the appointment of **Dr. Ivor Fix** as assistant to the director of the radiotherapy center. Dr. Fix, former senior radiotherapist at Addington Hospital, Durban, South Africa, was also a postgraduate clinical assistant at Christie Hospital and Holt Radium Institute, Manchester, England. He holds a diploma in medical radiotherapy from the Royal College of Physicians and Surgeons, London.

Jean Armstrong, R.N., has been promoted from assistant director of nursing to director of nursing at Hollywood Presbyterian Hospital, Los Angeles, succeeding **Winifred Scott, R.N.,** who is retiring. Miss Armstrong is a graduate of Hollywood Presbyterian Hospital's school of nursing, and was a school health nurse in Glendale, Calif., for four years. Prior to Miss Scott's appointment as director of nursing in 1957, she was supervisor of nurses in the medical and surgical wards of the hospital.

Jean Armstrong

William J. Yeats, former administrator of Wallowa General Hospital, Enterprise, Ore., is now administrator of Tri-State Memorial Hospital, Clarkston, Wash.

Dr. Felix P. Heald has been appointed director of adolescent medi-

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As research in hospital sepsis grows, evidence mounts that housekeeping methods and equipment play a critically important role in the control of cross-infections. The removal of dangerous bacteria-laden dust from all surfaces — floors, walls, ceilings, mouldings — is fast being recognized as essential to an adequate program of control.

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cine for Children's Hospital of the District of Columbia. Prior to this appointment, Dr. Heald was with the adolescent unit of the Children's Medical Center, Boston.

Della Felix has retired as superintendent of nurses at Missouri Delta Community Hospital, Sikeston, Mo., after three years in that post and 46 years of active duty as a registered nurse. She has been succeeded by **Mildred Brewer Gallagher,** who had been a supervisor at the hospital before taking a position with the Mississippi County Public Health Service.

Kathlyn V. Bettington has been named director of dietetics at Butterworth Hospital, Grand Rapids, Mich.

Sister Perboyre, R.R.L., is now the medical record librarian at Sacred Heart Hospital, Pensacola, Fla. Sister Perboyre came to the hospital from Sisters of Charity Hospital, Buffalo, N.Y., where she was an instructor.

Wyndal B. Rhodes has been named director of pharmaceutical services for the Miners Memorial Hospital Association located in the Appalachian Mountain coal mining area of West Virginia, Kentucky and Virginia. Mr. Rhodes received B.S. degrees in chemistry and pharmacy from West Virginia University. He was pharmacist at Fairmont Hospital, Fairmont, W. Va., and later was rotating pharmacist for several of the Miners hospitals. Mr. Rhodes is a member of the American Pharmacists Association and the American Society of Hospital Pharmacists.

C. P. Hutchinson has been appointed personnel director of Jewish Hospital, St. Louis. Mr. Hutchinson received his bachelor of science degree in business administration from Washington University.

Rhea C. Ackerman has been appointed director of patient relations for Hollywood Presbyterian Hospital, Los Angeles. She has previously been director of public and patient relations for Cedars of Lebanon Hospital, Los Angeles, and assistant administrator of Children's Hospital, Los Angeles.

Ruth DeFallot, R.R.L., has been named medical record librarian at Lakeland General Hospital, Lakeland, Fla.

Preston Bennett, Jr. has been appointed pharmacist at East Coast Hospital, St. Augustine, Fla.

Shirley Evans has been named director of nursing at Memorial Hospital, St. Joseph, Mich.

Robert C. Reid is the new personnel director for Lakeland General Hospital, Lakeland, Fla.

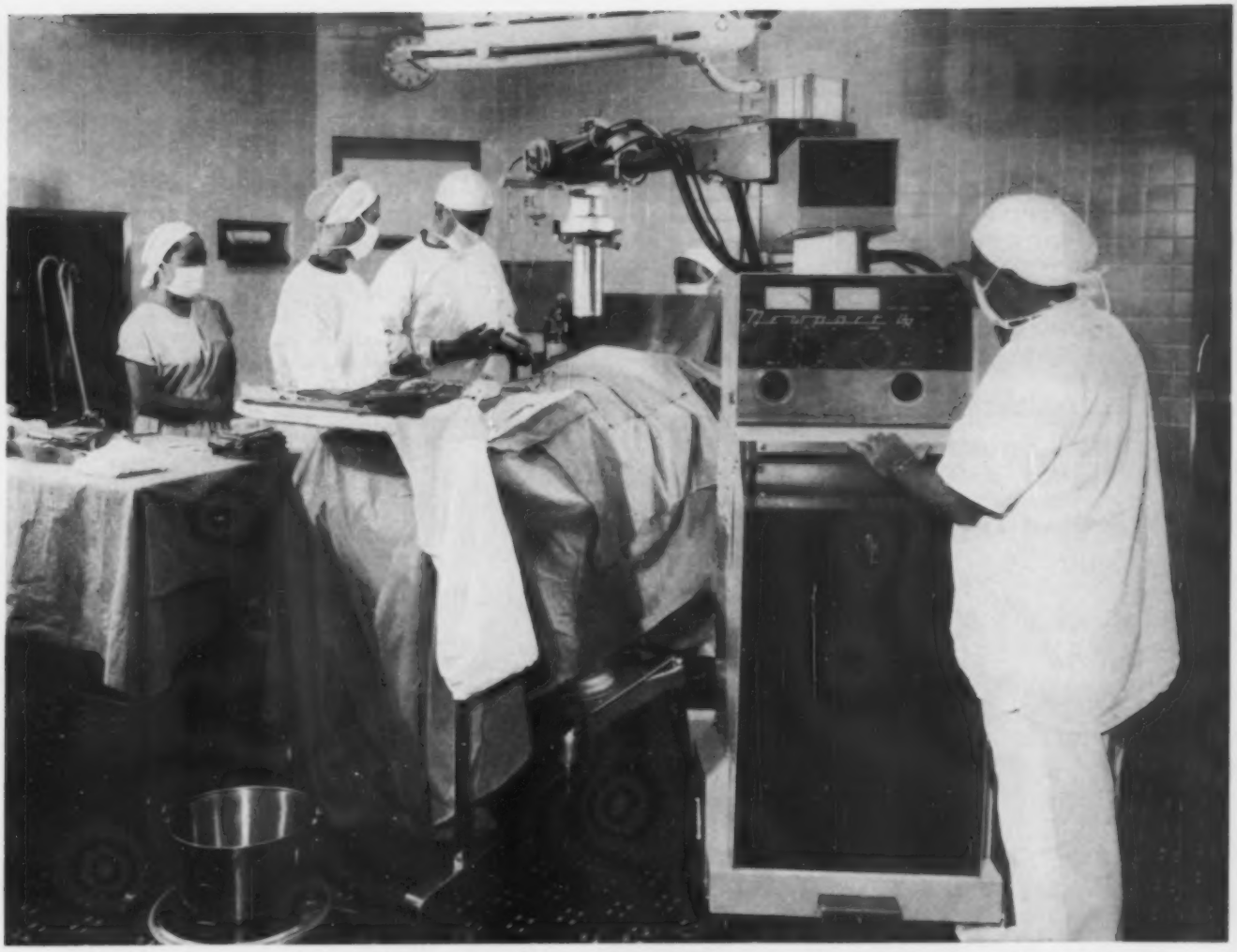
Dr. Clynn Roberts Ford has been named assistant chief of surgical service at Veterans Hospital, Salt Lake City. He is a graduate of Northwestern University Medical College.

Sadie Swatzburg has returned to her former post as director of the social service department of Jewish Memorial Hospital, New York, after six years in Detroit where she was associated with Metropolitan Hospital. The department has also added to its staff **Sheila Perman,** a graduate of Adelphi College School of Social Work, who will be responsible for the hospital's maternity and pediatric services.

Miscellaneous

W. Taylor Morrow has been appointed administrator of the Joint Public Charity Hospital Board, Montgomery, Ala. Mr. Morrow has been associated with a hospital consulting firm for the last three years. He is a

(*Continued on Page* 204)



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graduate of the program in hospital administration at Northwestern University, and served his administrative residency at Southern Baptist Hospital, New Orleans.

Joseph A. Oddis has been named director of the American Pharmaceutical Association's division of hospital pharmacy effective June 1 and assistant secretary of the American Society of Hospital Pharmacists. As director of the A.P.H.A. division of hospital pharmacy, Mr. Oddis will succeed **Paul F. Parker,** who resigned to accept the positions of director of pharmacy and central supply at University Hospital, University of Kentucky Medical Center, and assistant professor of pharmacy at the University of Kentucky College of Pharmacy, Lexington, Ky. Mr. Oddis is currently staff representative on the American Hospital Association's Council on Professional Practice. He served as pharmacist at Mercy Hospital, Pittsburgh, and as chief pharmacist at Western Pennsylvania Hospital, Pittsburgh. Mr. Oddis has been vice president of the Illinois Society of Hospital Pharmacists and president of the Western Pennsylvania Society of Hospital Pharmacists.

Dr. S. Bernard Wortis has been appointed dean of the New York University School of Medicine and Postgraduate Medical School and deputy director of the N.Y.U. Medical Center, New York. Dr. Wortis will retain his present position as professor and chairman of the department of psychiatry and neurology at the center. He is a consultant in psychiatry and neurology and is the editor of the Yearbook of Neurology, Psychiatry and Neurosurgery. Dr. Wortis succeeds **Dr. Donal Sheehan.**

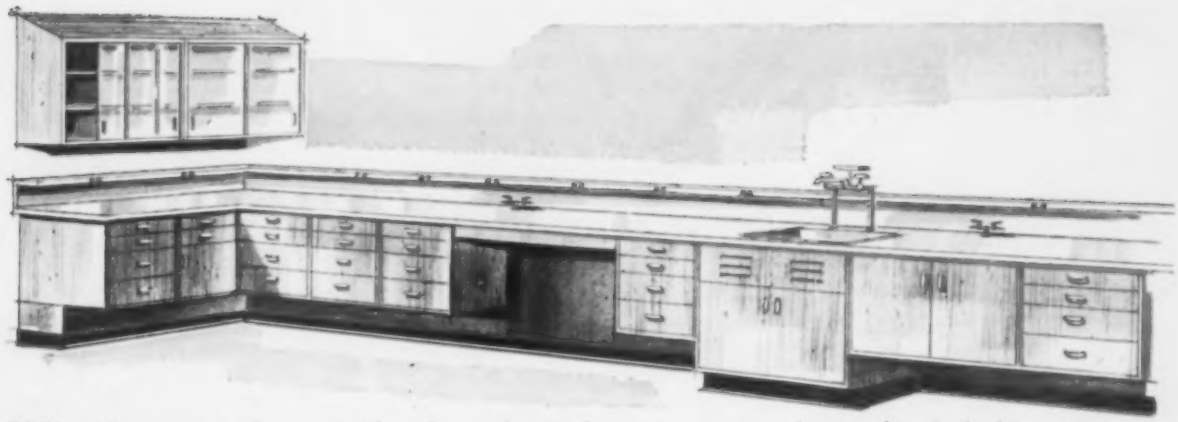
Adaline C. Hayden, associate editor of *Standard Nomenclature of Diseases and Operations,* American Medical Association, has resigned her position effective July 1. Mrs. Hayden has been appointed director and consultant to the medical records departments of the 17 Shriners Hospitals for Crippled Children located throughout the United States, Canada and Mexico.

Deaths

Carroll D. Hill, administrator of Children's Hospital, Baltimore, and formerly administrator of Union Memorial Hospital, Baltimore, died last month. Mr. Hill was a former president of the Maryland-District of Columbia-Delaware Hospital Association and a member of the American College of Hospital Administrators. He was also a former member of the Board of Maryland Hospital Service, Inc. (Blue Cross). Mr. Hill was a graduate of Columbia University's first class in hospital administration.

Winifred Howard Erickson, director of dietetics at Ancker Hospital, St. Paul, Minn., died March 27. She had been president of both the state and national dietetic associations. In 1956, she represented the United States at the International Congress of Dietitians in Rome. She was a graduate of the Wisconsin State College at Menomonie and also graduated in home economics and dietetics from the University of Wisconsin. Throughout her professional career, Mrs. Erickson had been affiliated with many professional societies.

Lauretta Paul, administrator of William Booth Memorial Hospital, Covington, Ky., died recently of a heart attack. Miss Paul was for many years administrator of Pontiac General Hospital, Pontiac, Mich., before going to the Booth hospital.



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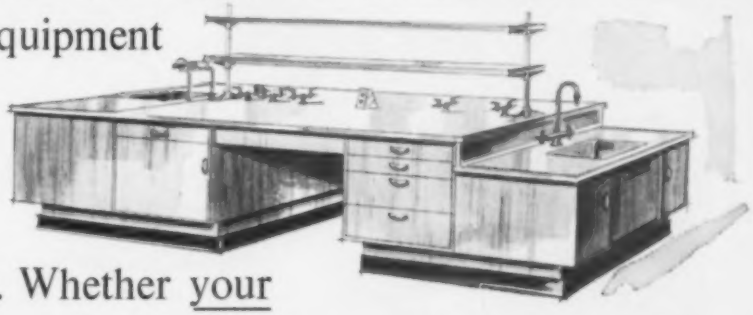

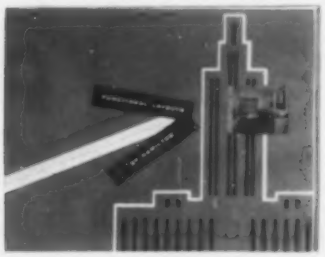

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Federal Workers Choose a Health Program

(*Continued From Page* 96)

In the world of hospital benefits, it's usually the "extras" that show up the real difference. It's a disarming word, easy to slough off, but the fact is that one can usually expect a bill for "extras" equal to if not more than the bill for hospital room and board. "Extras", of course, include such things as drugs, dressings, x-rays, use of operating room, lab tests, blood analyses, and so forth.

The service plan treats these extras the same way it treats room and board – as another part of the total hospital "package," as necessary service to be covered in full. All covered extras are provided by the service plans without cost to the patient – 30 days of unlimited extras in the Low Option and 120 days of unlimited extras in the High Option.

Under the indemnity plan one must pay a "deductible" of the first $50 of those extras plus 25 per cent of the remainder in the Low Option, a deductible of $50 plus 20 per cent of the remainder in the High Option. Of course, the patient may have already satisfied that deductible in medical bills prior to hospitalization – in that case, he pays a straight 25 per cent or 20 per cent of the charges on extras.

Once again, assuming that extra hospital charges will be the same as room and board charges – $20 per day:

Low Option Service
(at 30 days) . . .$ 600.00 value
Low Option Indemnity
(for 30 days) . . .$ 412.50 value
High Option Service
(for 120 days) . .$2400.00 value
High Option Indemnity
(for 120 days) . .$1880.00 value

Under the service plan, both Low and High, the patient paid out nothing for hospital room and board plus extras. Under the indemnity plans, he paid out $275 for 30 days under the Low Option, or $800 for 120 days under the High Option.

Here again, as with hospital room and board charges, the costs for medical and surgical care vary from place to place across the country. Service plan benefits are designed with this in mind – the service plan will pay doctors directly according to a schedule (a list of prices for over 100 specific operations and procedures) that is worked out with the doctors themselves in each locality, and realistically based on the prevailing fees for that area.

In certain "service areas" covering more than half of federal employes, participating doctors have agreed to accept these fees as "payment in full" if the patient's annual family income is not over a certain amount ($4000 for a single person, $6000 if a member of a family under the High Option – $2500 for a single person, $4000 if a member of a family under the Low Option).

There are some areas where the service agreement does not apply. In these cases the service plan will pay the doctor according to a national schedule of fees ($300 maximum on the High Option, $200 maximum on the Low Option).

In contrast, the indemnity plan will pay doctors and surgeons a straight percentage of their fees. They'll pay 80 per cent under High Option, 75 per cent under the Low Option (assuming that the patient has already laid out his $50 deductible on the hospital extras – if he hasn't, he'll have to pay the first $50 of his phy-

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sician's bill and 25 per cent (Low) or 20 per cent (High) of the remainder. In no case will the whole doctor bill be paid in full.

For the patient whose income is considerably above the income ceilings and whose doctor may, therefore, ask a fee above the schedule, the likelihood is that there won't be much difference in medical-surgical benefits between the indemnity and service plans. But, depending on income and location, there will be a considerable difference for enough federal employes to make the service plan a "best buy" for medical-surgical benefits, too.

Both service and indemnity plans have "major medical" or "supplemental" features designed to take care of a broad scope of extra medical and hospital costs both inside the hospital and outside. These cover, among other things, physician home and office visits, drugs, transfusions, prosthetics, private nurses, and costs for prolonged illnesses.

There are also deceptive differences between the service and indemnity supplemental benefits. For example, in the literature, the indemnity pays its benefits after a $50 deductible, the service after a $100 deductible on the High Option, $200 on the Low Option. But the patient is obliged to pay the indemnity plan deductible at the very start of his expenses while the service plan deductible is not applied until after he has received the service benefits allowed under the 30 day and 120 day programs.

Going back over the material described above, the patient can see that, as the service plan is expressed, by the time he's reached the point of paying out the deductible, he's had 30 or 120 days of hospital service benefits without cost to him. At that point, under the indemnity plan, he would have already paid for the deductible plus a husky percentage of charges.

Under the service plan, the majority of persons will rarely reach the point where the deductible feature must be invoked. Most nonhospital people are not aware that the average length of stay in a hospital is 7½ days, with the curve tapering off to about 30 days.

Should a patient be one of the few with a "catastrophic" illness, both service and indemnity plans will pay, after satisfying the deductible, 75 per cent of charges under the Low Option and 80 per cent under the High Option. The service maximums are $5000 (Low) and $20,000 (High). Indemnity maximums are $10,000 (Low) and $30,000 (High).

Benefits for maternity are, in most programs, set up as a special category. Under the Low Option, both indemnity and service plans will pay up to $10 per day for 10 days of hospital maternity care, with the service plan making generally larger payments toward the charges of obstetricians and anesthetists.

The High Option Indemnity Plan pays the hospital up to $15 per day for maternity admissions. The High Option Service Plan allows up to $100 regardless of the length of stay, which means that with modern short stays for most maternity cases, this is likely to result in a larger share of the maternity bill being covered than under a daily indemnity.

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ADMINISTRATIVE ASSISTANT — For public relations; B.S.H.A. or equivalent; hospital experience necessary; CAPITOL HOSPITAL, 35-beds, Milwaukee, Wisconsin. Address replies to: M. Margoles, M.D., 2733 East Newton Avenue, Milwaukee 11, Wisconsin.

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DIETITIAN—Therapeutic; 253-bed J.C.H.A. approved general hopsital, new kitchen and cafeteria. Send resume including experience and salary desired to Administrator, W. A. FOOTE MEMORIAL HOSPITAL, 205 N. East Avenue, Jackson, Michigan.

DIETITIAN—Therapeutic; large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries begin at $300 based on a 40 hour week; due to the need for more professional dietetic hours in the medcal center, dietitians are allowed overtime work and are paid at an hourly rate based on monthly salaries; two weeks vacation; social security; Blue Cross. Apply Director of Dietetics, BARNES HOSPITAL, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—Therapeutic; new 516-bed approved cancer research hospital; $4668.00 to start for 40 hour week and liberal fringe benefits; Apply to Personnel Director, ROSWELL PARK MEMORIAL INSTITUTE, 666 Elm Street, Buffalo 3, New York.

DIETITIANS—Staff or therapeutic; ADA approved; needed at once; approved, private, non-profit, 604-bed general hospital; good employee benefits; laundry service and meals; salary open. Apply to Miss Jo Ann Brown, Personnel Director, AKRON CITY HOSPITAL, 525 E. Market Street, Akron, Ohio.

(Continued on page 212)

classified advertising

POSITIONS OPEN

DIETITIANS—Neuropsychiatric hospital — 38 miles north of New York City; starting salary $4980 per annum; reasonably priced quarters available; ADA qualified. Contact Personnel Officer, VAH, Montrose, New York.

DIETITIAN—Chief; A.D.A.; with supervisory experience for 160-bed 27 bassinet general hospital fully approved by the JCAH and by the AMA for resident training; 40 hour week, salary open, 4 week vacation; also: Assistant Dietitian; salary open, 2 week vacation, 2 meals and laundry furnished; 40 hour week, 6 holidays; social security; Blue Cross and Blue Shield available. Send resume including experience, date available and salary desired to Miss G. A. Cooper, director, WOMAN'S HOSPITAL, 1940 East 101st Street, Cleveland 6, Ohio.

DIETITIAN—Executive; for 200-bed hospital, eastern Ohio; salary open with maintenance, vacation, sick benefits, and other benefits such as Blue Cross, Blue Shield and social security are available. Apply to Nell Robinson, Superintendent, THE EAST LIVERPOOL CITY HOSPITAL, East Liverpool, Ohio.

DIETITIAN—Vacancy at a central hospital within a chain of ten general hospitals with active APC's operated in coal mining region of eastern Kentucky, southwestern Virginia and southern West Virginia; ADA membership required with experience in teaching and/or therapeutics; food clinic experience desirable; salary at the rate of $4860 per annum; 40 hour week; 4 weeks paid vacation; 7 paid holidays; laundry of uniforms; social security. Call or write: THE MINERS MEMORIAL HOSPITAL ASSOCIATION, Box 61, 110 Logan Street, Williamson, West Virginia. Phone: BELmont 5-2424.

DIRECTOR OF NURSING—Modern, nonprofit, J.C.A.H. accredited, 125-bed general hospital; approved residency program; staff, Board Certified Specialists; dynamic, expanding organization; complete modern facilities; experience in nursing service, supervision and administration preferred; Master's or Bachelor's Degree required; $8,000 to $10,000 yearly, depending on qualifications; excellent personnel policies; all advantages of gracious living in beautiful suburb adjacent to Detroit, Michigan. Apply MO 302, THE MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIRECTOR OF NURSING SERVICE—Present director retiring; well organized department of nursing, enjoys excellent rapport with other departments; J.C.A.H. approved hospital; 289 adult beds, modern plant and equipment; located in picturesque Kanawha Valley; no school of nursing at present; prefer candidate with Master's degree and some experience either as director or assistant; progressive attitude on salary; 3 weeks paid vacation, sick leave accumulative to 30 full and 60 half days; truly a desirable position. Apply MO, 293, THE MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

(Continued on page 214)

Troy WX® washer-extractor pays for itself

A first person report by John Frantonius, Chief Engineer, Highland Park Hospital, Highland Park, Illinois.

"Our existing laundry facilities couldn't handle the extra laundry from a 35-bed Medical Pavilion acquired three years ago by the Highland Park Hospital Foundation. So it was done outside, at a cost of $7,200 a year. To lower this cost and increase our productivity to handle another 60-bed expansion, we purchased a 375 lb. TROY WX WASHER-EXTRACTOR, replaced a 40 lb. tumbler with a 100 lb. TROY Tumbler, and replaced a two-roll ironer with a 120 in., six-roll TROY SPEEDLINE Ironer.

"With our new TROY WX, we've increased our daily productive capacity 50.7%, slashed per load production time 22%, raised our total capacity 87.5%, and substantially reduced our production costs. In fact, the savings on Pavilion laundry costs alone *will more than pay for our new* TROY WX WASHER-EXTRACTOR!

"Laundry working conditions are improved, too. The Bifurcator fan on the TROY WX eliminates the rush of steam after extraction plus improving extraction so clothes come out *just damp enough to be put directly into the ironer*. The laundry stays cleaner because we're removing virtually dry clothes from our TROY WX . . . floors don't have to be mopped dry.

"We like the TROY WX features of spray-rinse suds removal and automatic dispensing of soap additives during cycle phases, too.

"We checked the products of three other manufacturers before purchasing, and we are very satisfied with our decision. We feel that we have received a superior product. The savings that are anticipated will pay for the TROY WX WASHER-EXTRACTOR in 2½ years."

Whether you're planning a new hospital laundry or an expansion of your present one, there's a TROY WX WASHER-EXTRACTOR to meet your needs most economically. Available in 25 lb., 100 lb., 200 lb. and 300 lb. capacities.

WRITE DEPT. MH-560 FOR DETAILED BULLETIN

Troy®

WX® WASHER-EXTRACTOR

100 Lbs., 200 Lbs., 375 Lbs.

LAUNDRY MACHINERY

Division of American Machine and Metals, Inc.

EAST MOLINE, ILLINOIS

Divisions of American Machine and Metals, Inc., New York 7, New York

TROY LAUNDRY MACHINERY • RIEHLE TESTING MACHINES • DE BOTHEZAT FANS • TOLHURST CENTRIFUGALS • FILTRATION ENGINEERS • FILTRATION FABRICS • NIAGARA FILTERS • UNITED STATES GAUGE • RAHM INSTRUMENTS • LAMB ELECTRIC COMPANY • HUNTER SPRING COMPANY GLASER-STEERS CORPORATION

classified advertising

POSITIONS OPEN

DIRECTOR SCHOOL OF NURSING—For accredited diploma school, student body of 160; Master's degree required; 40 hour week; salary based on preparation and experience; good personnel policies, social security, group hospitalization, hospital retirement plan, sick leave, 2-3 weeks paid vacation. Apply Personnel Director, SOUTHERN BAPTIST HOSPITAL, 2700 Napoleon Avenue, New Orleans 15, Louisiana.

DIRECTOR OF NURSING SERVICE—Associate; 416-bed 65 bassinet general hospital; all services; school of nursing, intern and resident program; Masters degree preferred; salary open, based on preparation and experience; expenses paid for personal interview. Forward detailed resume of training and experience to Mrs. Phyllis M. Loucks, Director of Nursing, BUTTERWORTH HOSPITAL, Grand Rapids 3, Michigan.

DIRECTOR OF NURSING SERVICE—284-bed general hospital expanding to 490-beds June 1960; most modern facilities; team nursing used throughout hospital; largest private hospital in community; excellent opportunity; Master's degree in administration or education with experience preferred; salary depends on qualifications and experience. Apply to Personnel Director, ST. JOSEPH'S HOSPITAL, 69 W. Exchange Street, St. Paul, Minnesota.

DIRECTOR OF NURSING—For 265-bed voluntary non-profit Episcopal hospital; present director retiring June 1st; new air-conditioned hospital completed in 1955; school of nursing building for 152 students under construction; Master's degree and successful experience in nursing service administration and/or nursing education desired; over-all responsibility. Address Hal G. Perrin, Administrator, BISHOP CLARKSON MEMORIAL HOSPITAL, Dewey Avenue at 44th, Omaha 5, Nebraska. Telephone: Regent 7300.

DIRECTOR OF NURSING—304-bed cancer research hospital and institute; no school of nursing; liberal vacation, sick leave and other fringe benefits, salary open, nursing administrative experience required and Masters Degree preferred. Personnel Director, ROSWELL PARK MEMORIAL INSTITUTE, 666 Elm Street, Buffalo 3, New York.

DIRECTOR OF NURSING SERVICE—242-bed, general, accredited hospital; experience desirable; excellent starting salary; progressive policies. Write James G. Carr, Jr., Administrator, MEMORIAL HOSPITAL OF NATRONA COUNTY, Casper, Wyoming.

DIRECTOR—Personnel; to organize and establish a centralized personnel department in a hospital which will have 253-beds and 44 bassinets upon completion this summer of a large expansion and remodeling program; candidate must have had good experience in this field; degree desirable; salary open; Send detailed resume of training, experience and salary desired to Robert G. West, Administrator, W. A. FOOTE MEMORIAL HOSPITAL, 205 N. East Avenue, Jackson, Michigan.

EDUCATIONAL DIRECTOR—For accredited school of nursing; 270-bed modern, accredited, general hospital and training institution; progressive community; excellent personnel policies; salary commensurate with degree and experience. Write Director of Nursing, ELYRIA MEMORIAL HOSPITAL, Elyria, Ohio.

ENGINEER—Chief; in charge of maintenance for 500-bed eastern hospital, which is old, and in active process of being modernized; the job requires an active, experienced man who can meet heavy demands on his time and ability; salary to $12,000. Write MO 286, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

INSTRUCTOR—Clinical; obstetric nursing; 225-bed hospital, J.C.A.H. accredited hospital; N.L.N. provisionally accredited school of nursing; 100 students; post graduate course or B.S. degree and teaching experience required; liberal personnel policies. Apply to Director of Nursing Education, ALLEN MEMORIAL HOSPITAL, Waterloo, Iowa.

INSTRUCTORS — Medical-surgical; fundamentals of nursing; and medical-surgical specialties; 225-bed hospital; N.L.N. provisionally accredited school of nursing, 100 students; B.S. and teaching experience desirable; liberal personnel policies; minimum salary for qualified person $400 per month. Apply to Director of Nursing Education, ALLEN MEMORIAL HOSPITAL, Waterloo, Iowa.

INSTRUCTORS—Clinical; one nursing arts, one medical-surgical, also one evening supervisor; excellent personnel policies. Apply Director of Nursing, BUFFALO GENERAL HOSPITAL, Buffalo 3, New York.

INSTRUCTOR—Medical and surgical; Degree in Nursing or Nursing Education or equivalent; salary commensurate with degree and/or experience; 4 week vacation, sick leave, etc. Write giving background and salary requirements to: Personnel Director, ST. RITA'S HOSPITAL, Lima, Ohio.

INSTRUCTOR—Medical surgical nursing; B.S. degree and one year experience required; 136-bed hospital; NLN fully accredited diploma school of nursing with enrollment of 50-60 students; starting salary $5,100; excellent personnel policies; position available August 1960. Write to Director of Nursing, PROVIDENCE SCHOOL OF NURSING, Sandusky, Ohio.

INSTRUCTOR—Medical & surgical; Degree in Nursing or Nursing Education, 150-bed hospital, modern; Central Pennsylvania; $4800 to start; send background information. CLEARFIELD HOSPITAL, Turnpike Avenue, Clearfield, Pennsylvania.

LIBRARIAN—Registered medical record; 100-bed approved general hospital; good living and working conditions. Apply Administrator, G. N. WILCOX MEMORIAL HOSPITAL, Lihue Kauai, Hawaii.

LIBRARIAN—Medical records assistant; 670-bed general hospital with large out patient service; I.B.M., terminal digit and sound-ex procedures; opportunity to supervise large staff; liberal personnel policies. Apply Personnel Director, HARPER HOSPITAL, Detroit 1, Michigan.

LIBRARIAN—Medical record; registered; with supervisory experience for 160-bed 27 bassinet general hospital fully approved by the JCAH and by the AMA for resident training; 40 hour week, salary open and commensurate with ability and experience. Send resume including experience, date available and salary desired to Miss G. A. Cooper, Director, WOMAN'S HOSPITAL, 1940 East 101st Street, Cleveland 6, Ohio.

LIBRARIAN—Chief medical record; two adjoining hospitals — 6 years in operation — 300-bed general, 100-bed pediatric under one administration, one record room, in the Texas Medical Center, Houston, Texas; fully accredited by Joint Commission; residency training programs with medical school affiliation, outpatient department; twenty one employees including four assistant RRL's; unit system; previous experience as chief or assistant chief librarian; salary open, commensurate with experience. Apply to Administrator, ST. LUKE'S EPISCOPAL HOSPITAL — TEXAS CHILDREN'S HOSPITAL, Texas Medical Center, Houston 25, Texas.

classified advertising

POSITIONS OPEN

NURSE—Registered; general duty in 35-bed sanitarium located in Santa Cruz, California a seaside resort area, population 27,000, 1½ hour driving distance from San Francisco, California; pleasant working conditions, starting salary $342 per month includes meal on duty plus $15.00 differential for 3 P.M. to 11 P.M. shift; 40 hour week, other fringe benefits. BATTERSON NURSING HOME, 2555 Mattison Lane, Santa Cruz, California.

NURSES—General duty; for 320-bed general hospital; only a few blocks from Lake Michigan beach and Lincoln Park; near Chicago loop; hospital accredited by J.C.A.H. and school of nursing accredited by N.L.N; apartments available close to hospital; liberal personnel policies; must be eligible for Illinois registration; openings on all shifts. Write Director of Nursing, AUGUSTANA HOSPITAL, 411 W. Dickens Avenue Chicago 14, Illinois.

NURSES—Registered; operating room and general duty for 350-bed hospital in western suburb, 16 miles west of Chicago's loop; starting salary for experienced operating room nurses $350; starting salary for general duty $325; differential of $15 for P.M. and night shifts; compensation of $2 a day for weekend duty, 6 paid holidays and other liberal benefits. Apply Mrs. Strong, Personnel Director, MEMORIAL HOSPITAL, Elmhurst, Illinois.

NURSES—Graduate staff; for general floor duty; pediatric nurses for all 3 shifts; obstetric nurse 11-7; 200-bed general hospital; starting salary for registered nurses with experience, $325; liberal personnel policies, 40 hour week, social security, Blue Cross, retirement plan. Write Personnel Director, PEKIN PUBLIC HOSPITAL, 1317 Park Avenue, Pekin, Illinois.

NURSES—Registered; for new 30-bed general hospital located 30 miles northeast of New Orleans, Louisiana, on U. S. Highways 11/190; salary commensurate with qualifications and experience; send photograph, resume, and date of availability to: Thos. L. Qualey, Administrator, SLIDELL MEMORIAL HOSPITAL, 1125 East Hall Avenue, Slidell, Louisiana.

NURSES—Graduate staff and head; female; opportunity for extended orientation to psychiatric nursing practice at beginning salary; inservice training in supervision offers advancement; excellent personnel policies; salaries $295 to $384 and $342 to $444 monthly; complete room and board available approximately $35 month. For details write; Director of Nursing, NEW JERSEY STATE HOSPITAL, Greystone Park, New Jersey. (35 miles west of N.Y.C.)

NURSES—Registered; 100-bed hospital; general staff beginning salary $220.00, complete maintenance; 3-11 and 11-7 supervisor $260.00 complete maintenance; liberal fringe benefits. Apply Director of Nurses, MARTINSVILLE GENERAL HOSPITAL, Martinsville, Virginia.

STAFF POSITIONS—All clinical areas including psychiatry, respiratory-rehabilitation center; beginning salary $300 monthly; periodic increases; 3 weeks annual vacation; opportunity for college study, bachelor's degree program. Write Head, Department of Nursing service, EUGENE TALMADGE MEMORIAL HOSPITAL, MEDICAL COLLEGE OF GEORGIA, Augusta, Georgia.

PHARMACIST—Registered; male or female; for 400-bed general hospital in Hawaii, liberal personnel policies, hospitalization coverage, group life insurance, retirement, 40 hour week; state salary desired. Write Personnel Director, THE QUEEN'S HOSPITAL, P.O. Box 861, Honolulu, Hawaii.

SUPERVISOR—Operating room; 200-bed general hospital; NLN fully accredited school of nursing; 40 hour week, salary open; liberal personnel policies. Apply Director of Nursing, BENEDICTINE HOSPITAL, Kingston, New York.

SUPERVISOR—Operating room; JCAH accredited 350-bed general hospital, with NLN accredited school of nursing; operating room suite is new, modern and completely air conditioned; advance preparation and experience required; excellent personnel policies including group life insurance, Blue Cross, social security, vacation and sick leave benefits; salary open. Write stating age, experience, salary desired to Personnel Director, BETHESDA HOSPITAL, Oak St. & Reading Road, Cincinnati 6, Ohio.

SUPERVISORS—Excellent opportunities for qualified nurses, in new 200-bed wing to open with extensive clinic facilities modern equipped; fully approved by Joint Commission; intern-resident program, fully accredited school of nursing; liberal benefit program, 4 weeks vacation. Apply Personnel Director, CHRIST HOSPITAL, Cincinnati 19, Ohio.

SUPERVISOR—Obstetrical; responsible for the administration of a 53-bed obstetrical unit consisting of a delivery room and two floors; present hospital has 575-beds; starting a $2,500,000 building in the Fall which will house an entirely new obstetrical unit; department has full time obstetrical instructor; large school with no recruitment problem; salary $4740 with six month increases to $5340; retirement plan in addition to social security; hospital pays 5% of salary into fund and employee 3%; after 5 years of service, hospital provides a life insurance policy for the employee equivalent to a year's salary; hospital pays the policy; other liberal personnel policies and attractive living and teaching facilities; each room in the residence has it's own bath and shower; hospital located in a beautiful 40 acre park; community has many cultural opportunites; one college in city; four universities have extension center or extension courses in the city qualifications: Baccalaureate Degree and past supervisory experience. Apply Director of Nurses, The READING HOSPITAL, Reading, Pennsylvania.

SUPERVISOR—Pediatric; new, modern, well equipped 40-bed, fully accredited general children's hospital; degree and experience in pediatrics preferred; salary commensurate with qualifications. Apply Administrator, MARY BRIDGE CHILDREN'S HOSPITAL, Tacoma 5, Washington.

TECHNICIAN—Qualified in both laboratory and X-ray for new 50-bed general hospital; 3 technicians employed; salary open. Apply MO 304, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

TECHNOLOGIST—Medical; for 7 doctor clinic located in college town of 14,000; modern building and laboratory, salary open dependent upon experience and qualifications. Apply Business Manager, DAVIS CLINIC, Mt. Pleasant, Michigan.

TECHNOLOGISTS — Registered medical; two; for J.C.A.H. 120-bed hospital, under direction of pathologist; starting salary for new graduate $375.00; increased amount for experienced technologist; attractive personnel policies. Apply Director of Personnel, DE PAUL HOSPITAL, Cheyenne, Wyoming.

(Continued on page 216)

classified advertising

POSITIONS OPEN

THERAPIST—Occupational; for 253-bed J.C.A.H. approved hospital; will serve medical-surgical patients, as well as those patients on our new 30-bed mental health unit; must have a degree; salary commensurate with qualifications. Contact Administrator, W. A. FOOTE MEMORIAL HOSPITAL, 205 N. East Avenue, Jackson, Michigan.

THERAPIST—Staff physical; willing to consider recent graduate; in and outpatient work; well equipped department; good starting salary. Write Assistant Administrator, MEMORIAL HOSPITAL, Casper, Wyoming.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

900 N. MICHIGAN AVENUE, CHICAGO

ADMINISTRATORS—(a) Director medical education and research, new department, outstanding teaching institution, 600-beds, university affiliated; educational service includes 45 residents, 15 interns, 40 undergraduates; leading city. (b) Administrator, construct 50-bed hospital with proposed expansion 250; excellent financial opportunity; Atlantic Coast sea resort. (c) Assistant administrator, 260-bed hospital; large outpatient department; 150 in school of nursing; university city, midwest; minimum $6500. (d) Assistant administrator; accounting experience for office management; also purchasing, and department control; 160-bed hospital, Pennsylvania. (e) Administrator, 25-bed hospital, south; prefer background x-ray, laboratory; $6600. (f) Assistant administrator, 300-bed well renowned hospital, New York; $7-10,000. MH 5-1

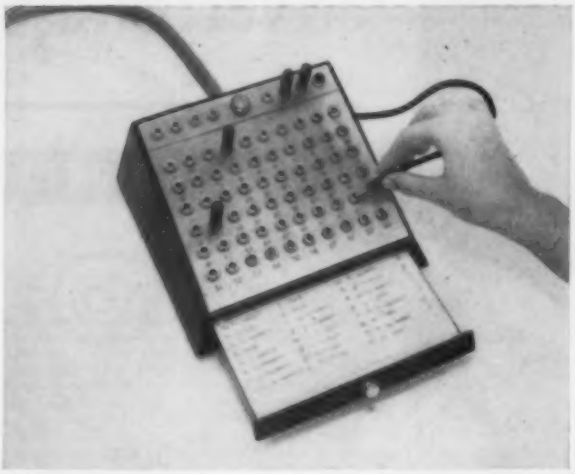
ADMINISTRATIVE PERSONNEL — (a) Business manager, 80-bed hospital opens September; tourist, resort area south. (b) Accountant; supervise 12 in department; 400-bed hospital, commuting distance Chicago; $7-8500. (c) Director, volunteers, public relations 315 bed hospital near N.Y.C., $7500-8500. (d) Food service organization sales representative; hospital administration experience desirable; excellent opportunity for development; $7200-8000 start. MH 5-2

ANESTHETISTS—(a) Small clinic and hospital near Mexican border college town, health resort; also assist administrator, $9000. (b) Male anesthetist, 200-bed hospital, Lake Michigan summer-winter resort; $8400 start; (c) Share responsibility for service 80-bed hospital near New Orleans, $7200. (d) Only one on staff, 25-bed hospital, California; start $7800. MH 5-3

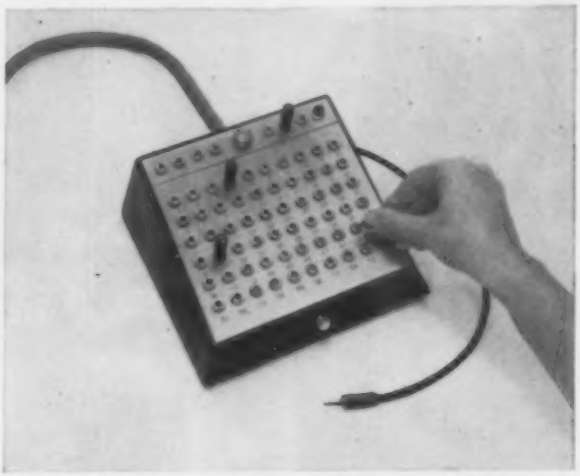
DIETITIANS—(a) Chief, new hospital, commuting distance St. Louis; $6000. (b) Chief, 150-bed hospital; new kitchen Great Lakes resort area; $6600. (c) Head large department, 250-bed hospital; Atlantic coast ocean resort; top salary. MH 5-4

(Continued on page 218)

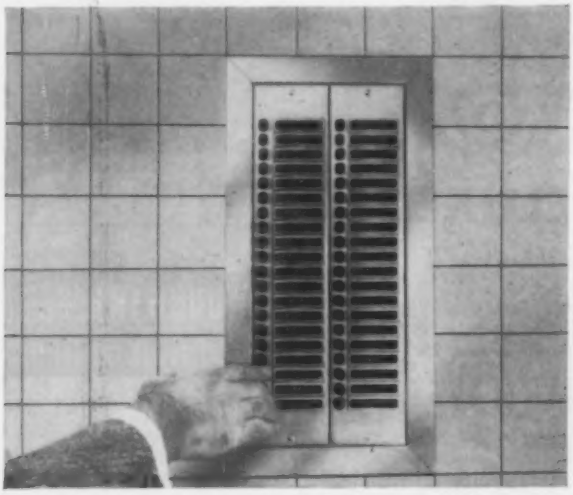
See How the AUTH PAGESAVER SYSTEM Can Boost the Efficiency of Your Hospital!



▲ *Before paging a doctor the operator checks her Pagesaver to see if he is in the hospital. If he is, a white pilot light glows...*



▲ *...but if he is not, she does not page him. Instead, she inserts an "alert" plug in his receptacle on the Pagesaver and leaves it there.*



▲ *When the doctor registers IN, his flashing name on the entrance register informs him that a message awaits him...*

▲ *...and the operator, informed of his arrival by the flashing light of the "alert" plug in her Pagesaver, proceeds to page him.*

The new Auth Pagesaver System benefits all—the hospital, its patients, and its staff. With this unique new system to inform her which doctor's aren't in—and to signal her when they come in—the telephone operator won't waste time paging men who aren't there. Patients will rest better with fewer annoying page calls—and their doctors will be located faster when they are needed. Doctors will be alerted earlier to emergency calls. And the hospital, its efficiency and morale boosted by the elimination of hit-or-miss paging, benefits from the resulting goodwill.

All Pagesaver equipment is small and compact, occupying little space. The cost of the system is small, too, in comparison with the cost of other doctors' in-and-out register systems.

If you would like to know more about the Pagesaver System—and other modern signaling and communication systems to increase the efficiency of your hospital—the Auth representative will gladly discuss them with you. No obligation, of course.

Auth SINCE 1892

Auth Electric Company, Inc.
LONG ISLAND CITY 1, NEW YORK

SPECIALISTS IN HOSPITAL SIGNALING AND COMMUNICATION SYSTEMS, CLOCK AND FIRE ALARM SYSTEMS

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—Continued

DIRECTORS OF NURSING—(a) Director of Nurses; have capable director nursing service and director of education, 600-bed hospital; NLN school 250 students; $10,000. (b) Director of nursing service, school; 350-beds, 150 students; commuting distance San Francisco; attractive salary. (c) Director of nursing service, 100-bed hospital near Cape Cod; $7-$9000. (d) Director of Nurses, 160-bed hospital, Ohio lake resort; $7-$10,000. (e) Male director of nurses, large hospital for criminally insane, midwest; $7500. MH 5-5

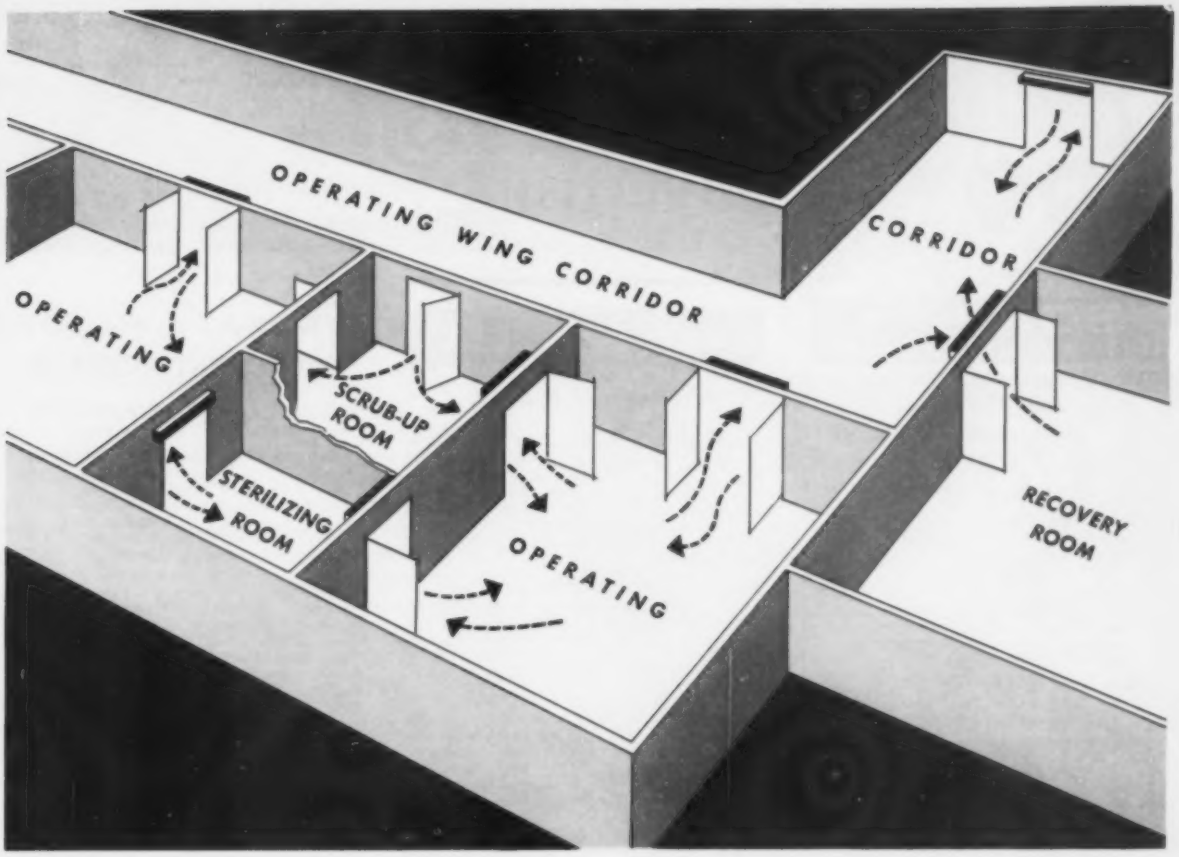
EXECUTIVE HOUSEKEEPERS—(a) Most progressive hospital and home for aged; beautiful Lake Michigan suburb; $6000. (b) Head department 250-bed hospital near Hollywood, California; good salary. MH 5-6

MEDICAL RECORD LIBRARIANS—(a) Chief, 100-bed hospital, friendly picturesque town, resort area of Catskill Mountains, to $560 per month. (b) Head department 250-bed hospital; good organizer required; start $500; college town, Indiana. (c) Able administrator, take charge most modern Southern California hospital; cooperative board; $6000 up. MH 5-7

ADMINISTRATORS—(a) Direct medical education; fully-accredited, 350-bed, general hospital; 40 residents & interns; $15-18,000 plus excellent benefits; south. (b) By June; new 50-bed, general hospital; plans to expand rapidly to 250-beds; will be staffed by Board men; requires MHA with residency completed; northeast. (c) Medical director to develope new residency program; new post; full charge; new 400-bed general hospital; $15-18,000; south. (d) Male or female; fairly large, JCAH general hospital; 300 employees; degree not necessary, but requires experience; Florida. (e) Medical or non-medical; new, 90-bed, voluntary general hospital; requires several years experience; $10-12,000; warm, dry climate; southwest. (f) With several years experience; new 240-bed hospital; near large manufacturing city, midwest. (g) Assistant; 450-bed, fully-accredited, medical-school affiliated hospital; requires equivalent to MS plus minimum 2 years as assistant 200-bed hospital; $12,000; large city. (h) Assistant; full-charge, all plant services; medical school affiliated, JCAH general hospital; to $10,000; California.

ADMINISTRATIVE POSTS—(i) Chief accountant with institutional experience, fully qualified every phase of accounting; report direct to comptroller; 300-bed hospital; east. (j) Business manager-accountant; new NCR machine installed; fairly large, general, cor-

(Continued on page 220)



Clear the way for faster traffic flow and greater hospital efficiency with

STANLEY MAGIC-DOOR® Equipment

An investment in automatic door operation will bring you big returns in benefits—faster traffic flow, increased efficiency, savings in time, controlled isolation—*if the equipment you select offers dependability that assures no interruption of service!*

STANLEY MAGIC-DOOR equipment delivers such dependable performance day after day, year after year. There's a reason. Only Stanley has almost 30 years' experience to draw on in designing and manufacturing POWER-ENGINEERED automatic door operating equipment, with the power controlled throughout the opening and closing cycles. Stanley gives you unmatched selectivity, too, offering a complete line of controls, operators and accessories to meet every appearance, performance and service requirement. A nearby distributor will install and service the MAGIC-DOOR equipment you specify for new or existing doors that swing, slide or fold. Write for complete information and the name of the MAGIC-DOOR distributor in your area to STANLEY HARDWARE, Division of The Stanley Works, MAGIC-DOOR SALES, Dept. E, 74 Lake St., New Britain, Conn.

SALES, INSTALLATION AND SERVICE DISTRIBUTORS IN PRINCIPAL CITIES IN THE UNITED STATES AND CANADA

Deserving a place in your plans for progress

HARDWARE / AUTOMATIC DOOR EQUIPMENT / ALUMINUM WINDOWS

STANLEY
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AMERICA BUILDS BETTER AND LIVES BETTER WITH STANLEY

This famous trademark distinguishes over 20,000 quality products of The Stanley Works, New Britain, Conn.—hand tools • electric tools • builders hardware • industrial hardware • drapery hardware • automatic door controls • aluminum windows • stampings • springs • coatings • strip steel • steel strapping—made in 24 plants in the United States, Canada, England and Germany.

CANADIAN PLANTS: HAMILTON, ONTARIO AND ROXTON POND, P.Q.

For additional information, use postcard facing back cover.

classified advertising

POSITIONS OPEN

WOODWARD—Continued

poration hospital; Chicago. (k) Comptroller; duties; all books, reports, plus management, large real estate holdings of 400-bed, fully-approved hospital; midwest. (l) Finance officer; 300-bed, Methodist conference, general hospital; should be well-qualified fund raiser, writer, able public speaker; $8-10,000; permanent post.

DIRECTOR OF NURSES—(a) Degree preferred; responsible directly to administrator for 125 in department; 120-bed approved general hospital; to $8400; town 20,000; midwest. (b) Nursing service only; voluntary general hospital 125-beds; to $9000; lovely New England city 40,000.

EDUCATIONAL DIRECTORS—(a) Assistant; approved voluntary general hospital 150-beds; $5500; lake resort, college community 15,000; New England. (b) Fully accredited school enrolling 85; collegiate affiliated; 200-bed community hospital; excellent personnel policies; east.

EXECUTIVE HOUSEKEEPER—(a) Male only; full responsibility active department, 600-bed fully approved general hospital; midwestern university, industrial city 150,000. (b) Fully approved 300-bed medical school affiliated general hospital; eastern university center.

NURSE ANESTHETISTS—(a) Voluntary general hospital 75-beds; to $6000, full maintenance; small residential community fairly near Washington, D.C. (b) General hospital 40-beds working toward accreditation; no obstetrical department; to $8400; midwestern resort area.

PHARMACISTS—(a) State registry not required; 80-bed, approved, fully air-conditioned general hospital; high census; excellent personnel policies; lovely Florida resort area. (b) Chief: approved general hospital 200-beds; $6000; northeastern city 20,000.

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Day, Director
332 Bulkley Building
Cleveland 15, Ohio

ADMINISTRATOR—(a) 75-bed Ohio hospital. (b) Small new hospital, south central state. (c) R.N. 160 bed geriatric institution, east. (d) 50-bed nursing home, Ohio.

ASSISTANT ADMINISTRATOR—(a) 75-bed hospital, mid-west. (b) Business manager; 100-bed hospital, Pennsylvania. (c) Private clinic, east.

CHIEF ACCOUNTANT—(a) 375-bed hospital, west coast. (b) Large hospital, west of Chicago. (c) 200-bed hospital, New York.

DIRECTORS OF NURSING—(a) To $8200. (b) Assistants—nursing service; To $7200.

LABORATORY TECHNICIAN—(a) Private clinic, Ohio. (b) Laboratory and X-ray technician.

INTERSTATE—Continued

DIRECTOR—Plant maintenance; (a) 350-bed hospital, east. (b) New hospital, 250-beds, mid-west. (c) Executive housekeeper; 200-bed eastern hospital. (d) 250-bed hospital, near Philadelphia.

PHARMACIST—(a) $550; large Ohio hospital. (b) Chief; 400-bed teaching hospital, west. (c) Michigan; to $600.

MEDICAL RECORDS LIBRARIAN—To $500.

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(Continued on page 222)

engine power
BY CATERPILLAR

CAT DIESEL ELECTRIC SETS STAND GUARD AT ARMED FORCES INSTITUTE OF PATHOLOGY

PROVIDE STANDBY POWER NO HOSPITAL SHOULD BE WITHOUT

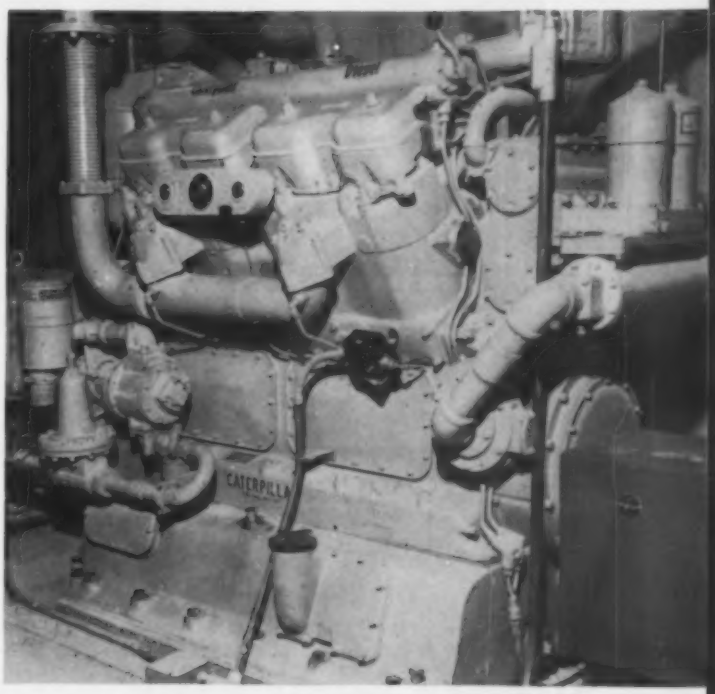
The Armed Forces Institute of Pathology, Washington, D. C., is an eight-story building that rises only five stories above ground. The other three are underground. Completed in 1954, the Institute has laboratories for investigative work in such fields as histochemistry, cytophysics, historadiobiology, histobacteriology—virus and tissue culture. The Institute supports modern medicine through pathological consultation, education, and research for the Armed Forces and civilian institutions.

The modern, windowless, blast-resistant Institute building must be protected against electrical failure. A Cat Diesel Electric Set provides the protection. Should normal power fail, the electric set takes over in seconds to provide power to keep going. Essential electrical power never vanishes.

No hospital is complete without standby electricity. Too many hospitals have inadequate or outmoded standby facilities. Brief power loss may bring tragedy.

Cost of an emergency electric set is small indeed compared to the risk without it. It is smaller still for hospitals which meet the federal government's requirements for matching funds.

Your Caterpillar Dealer will gladly survey the status of your present emergency power provisions. He will show you your needs and explain how you can be protected. There is no obligation. He's worth talking to because he has firsthand information on the most dependable line of diesel electric sets made. Call him for information, or write to:



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Engine Division, Caterpillar Tractor Co., Peoria, Ill., U.S.A.

ARMED FORCES INSTITUTE OF PATHOLOGY. Your hospital can be protected against power loss with the same kind of dependable diesel electric set this Institute has . . . Cat Diesel Electric Set.

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The **CHICAGO LYING-IN HOSPITAL AND DISPENSARY** of the University of Chicago offers a six-months course in obstetric nursing to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

UNIVERSITY OF MICHIGAN offers an 18 month course for nurses interested in anesthesia. Accredited by the American Association of Nurses Anesthetists. Unlimited opportunities for endotracheal intubations open chest, and neuro surgery anesthesia. Stipend provided. For information write "School for Nurse Anesthetists, UNIVERSITY MEDICAL CENTER, Ann Arbor, Michigan".

MT. CARMEL MERCY HOSPITAL offers an 18 month course in Anesthesiology to registered nurses of accredited schools of nursing. Approved by American Association of Nurse Anesthetists. Stipend provided. Write for complete details regarding theoretical and clinical teaching and requirements for entrance. School of Anesthesia, MT. CARMEL MERCY HOSPITAL, Detroit 35, Michigan.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition $100.00 approved by the American Medical Association. For further information, write the Director of Laboratories, BARNES HOSPITAL, 600 S. Kingshighway, St. Louis 10, Missouri.

BARNES HOSPITAL: Offers an 18 month post-graduate course in Anesthesia to registered graduate nurses. Theoretical requirements of the American Association of Nurse Anesthetists met, Miss Helen Vos, R.N., B.S., Educational Director. Clinical training includes all techniques and procedures. Stipend provided. For information, write Mrs. Dean Hayden, Director, School of Anesthesia, BARNES HOSPITAL, St. Louis 10, Missouri.

LUTHERAN MEDICAL CENTER, 4520 Fourth Avenue, Brooklyn 20, New York. "School for Medical Record Librarians" Classes being formed now for September 1961.

ANESTHESIA SCHOOL FOR NURSES, St. Joseph's Hospital, Lancaster, Pennsylvania, 18 month course AANA approved. No tuition. Stipend. Large clinical experience for students including great many endotracheal intubations. For complete details write Dr. N. Kornfield, ST. JOSEPH'S HOSPITAL, Lancaster, Pennsylvania.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, PROVIDENCE LYING-IN HOSPITAL, Providence 8, Rhode Island.

For additional information, use postcard facing back cover.

B-P STERILE *Rib-Back* BLADES

TRADITIONAL SUPERIORITY

CONTEMPORARY CONVENIENCE

The traditionally sharper carbon steel B-P RIB-BACK Blades in the contemporary sterile packages, designed for time-saving convenience. Individual unopened packages are ready for autoclaving—if desired.

The uniformity with which these individual, puncture-resistant, reinforced foil packages can be opened is a further safeguard of blade sterility.

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B-P RIB-BACK Blades are also available: RACK-PACK packages or 6 Blades of a size in rust-resistant wrappers.

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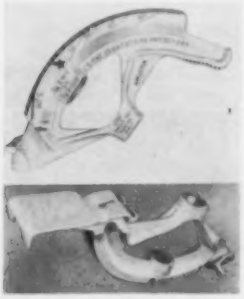
Edited by BESSIE COVERT

WHAT'S NEW

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form on page 259. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Appleton-Benfield Benders for Metallic Tubing

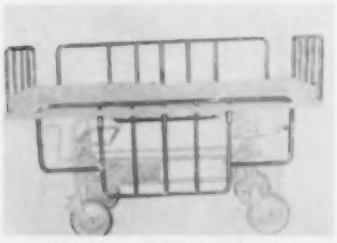
A new line of tools for hand bending electrical metallic tubing, rigid steel and



rigid aluminum conduit is now offered by Appleton. Added to its complete line of electrical fittings, the Appleton-Benfield Benders are universal precision tools of unique design, enabling one model to bend all three standard types of conduit. The work can be done by one man "on location" without expensive power benders. Features include: outriggers on hook to stabilize the tool and give the operator solid footing; extended foot treadle or "Powr-Jack" booster step for maximum foot leverage; exclusive degree scale; clear symbols on each side; lightweight and one-piece skidproof hook construction, and construction of unbreakable alloy malleable iron for maximum safety. A 12-page illustrated booklet, "How to Bend Conduit," accompanies the tool and provides full information on its use. **Appleton Electric Co., 1701 W. Wellington Ave., Chicago 13.**

For more details circle #777 on mailing card.

Vertical Side Rail for Standard Stretchers



A series of steel hangers incorporating frictionless nylatron bushings hold the new full length vertical or sliding side rail permanently on Hausted Standard Stretchers. Increased rigidity in the rail, as well as quiet operation, are effected by the nylatron bushings. The stainless steel rails have two height adjustments, operated by a concealed spring release, and the design permits maximum accessibility to head and foot of the patient. The Hausted Vertical Rails are 58 inches long and 14¾ inches high. **Simmons Co., Hausted Div., Medina, Ohio.**

For more details circle #778 on mailing card.

Model 832 Formula Sterilizer Is Low-Cost Unit

All operating and safety features of larger models are built into the low-cost Model 832 infant formula sterilizer for the small nursery. It has ample capacity for service to eight bassinets as it will process 32 four or eight-ounce bottles, with time and temperature cycling operation set by automatic controls. The manufacturer is prepared to offer, with the new formula sterilizer, room plans to convert limited available space into a com-

plete infant formula room. **American Sterilizer Co., Erie, Pa.**

For more details circle #779 on mailing card.

X-Ray Room Cup Holders Glow in the Dark

Reusable plastic holderettes for 14-ounce paper cups are now made to glow in the dark for use in x-ray rooms. Barium can be pre-mixed and stored in paper cups. When needed, the filled cups are taken from storage and the holderettes snapped on so that the barium is quickly located in the dark. **Dixie Cup Co., 24th & Dixie Ave., Easton, Pa.**

For more details circle #780 on mailing card.

Air Cool Blower Condenser for Rooftop Installation

The LSBC (Low Silhouette Blower Condenser) is a new type air cool blower condenser for use in rooftop locations. Noise is kept at a minimum and the shape allows for location on most roofs without reinforcing of roof members. **Dunham-Bush, Inc., 179 South St., West Hartford, Conn.**

For more details circle #781 on mailing card.

Sani-Mop Vac System Automatically Cleans Dust Mops

Dry mops, dusters, dust cloths and similar housekeeping tools are quickly and

automatically cleaned with the Sani-Mop Vac System. Time is saved and sanitary conditions and cleaning results are improved, since the dust does not get into the air. Components of the Sani-Mop Vac System include a slotted plate flush-mounted on floor or cabinet-top, Hoffman multistage centrifugal exhauster, Smooth Flow tubing, and a wet or dry separator, depending on the application. With an inlet valve, the Sani-Vac can be used for vacuum cleaning in conjunction with stationary systems. **U.S. Hoffman Machinery Corp., Dept. RN, Air Appliance Div., 103 Fourth Ave., New York 3.**

For more details circle #782 on mailing card.

Handy File Holds Business Cards

Designed for more efficient handling of business cards which are often misplaced, the new E-Z-File for desk-top use has revolving slots for the alphabetical filing of as many as 500 cards. The selector knob on the top of the file is turned to the desired letter, then pulled to eject the cards. The attractive, durable file of molded

plastic takes up minimum desk space. It is compact and efficient in use, economical in cost, and saves time in finding desired business cards and the irritation caused when they are not found. **T & H Industries, 8528 Fishman Rd., Pico Rivera, Calif.**

For more details circle #783 on mailing card.

(Continued on page 228)

Lenox Kick Bucket Has Conductive Rubber Bumper

Both carriage and removable 12-quart pail of the Lenox Kick Bucket are fabricated entirely from non-magnetic stainless steel. Increased floor spread prevents tipping and an electrically-conductive rubber bumper encircles the lower portion of the unbreakable carriage which is mounted on four two-inch conductive rubber swivel casters. All joints in both carriage and pail are welded to eliminate dirt-trapping crevices. **S. Blickman, Inc., 8400 Gregory Ave., Weehawken, N.J.**

For more details circle #784 on mailing card.

J&J Elastic Bandages Combine Comfort and Economy

Two new elastic bandages are introduced by Johnson & Johnson, Comprol Rubber Elastic Bandages and Adaptic Cotton Elastic. Comprol have high rubber content with maximum elasticity for exact, controllable compression, and the lightweight fabric makes them cool and comfortable. The stabilized construction reduces laundry shrinkage to a minimum and the bandages are provided in natural skin color. The new Adaptic Cotton Elastic Bandages provide elasticity for moderate compression which is fully restored by laundering. The long staple yarn used gives durability and the balanced construction ensures constant width. Both bandages are available in 2, 2½, 3, 4, and 6-inch widths, each protectively packaged in polyethylene. **Johnson & Johnson, New Brunswick, N.J.**

For more details circle #785 on mailing card.

Plastic Hamper Bag Helps Combat Infection

Formed of sturdy polyethylene, the new Aloe Plastic Hamper Bag is held on the hamper by a ¼-inch rubber band. When

the bag is full, the rubber band is removed and the open end of the bag tied in a knot, keeping fluids or contaminated linen confined for transport to the laundry with minimum opportunity for spread of bacteria. The bag is available in clear plastic for use in nursery, surgery and other areas, and in red transparent plastic for contagious wards or other places where there is definite contamination. **A. S. Aloe Co., 1831 Olive St., St. Louis 3, Mo.**

For more details circle #786 on mailing card.

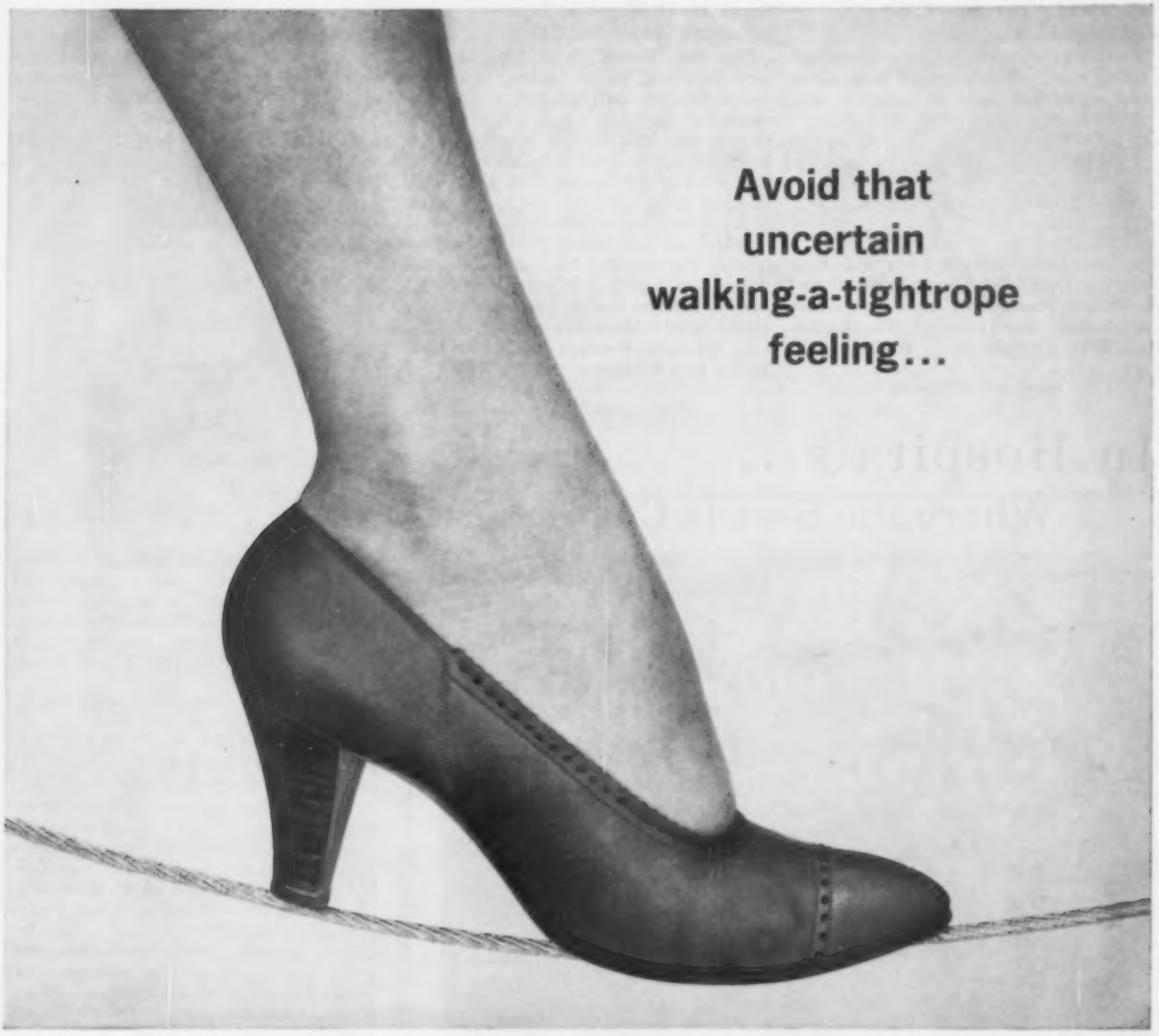
Automatic Flaked Icemaker Features Low-Cost Operation

Low-cost operation is a feature of the new Bastian-Blessing automatic electric flaked icemaker. It will produce approximately 250 to 350 pounds of flaked ice per day at minimum cost, dropping it into

a connecting insulated bin. The icemaker comes complete with storage bin, compressor and motor in a three-foot unit, with stainless steel facings, work top and backsplash. **The Bastian-Blessing Co., 4203 W. Peterson Ave., Chicago 46.**

For more details circle #787 on mailing card.

(Continued on page 230)

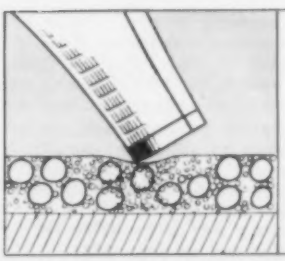


For positive traction underfoot, plus lasting beauty, use floor wax containing LUDOX—Du Pont's anti-slip ingredient

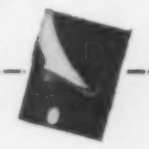
With "Ludox" in the floor wax you get added safety underfoot. "Ludox" acts like a brake that promotes easy, effortless walking. And you get the lasting beauty only a fine wax can give your floors. Scratches and scuffs can be buffed out without rewaxing. For more information and a list of suppliers, write us or mail coupon below.

DU PONT LUDOX® colloidal silica

BETTER THINGS FOR BETTER LIVING . . . THROUGH CHEMISTRY



In floor wax, microscopically small spheres of "Ludox" colloidal silica are mixed among larger wax globules. Under foot pressure the particles of "Ludox" bite into the softer wax globules, resulting in a snubbing action that makes walking more carefree and comfortable.



E. I. du Pont de Nemours & Co. (Inc.)
Industrial and Biochemicals Dept.
Room N-2533 MH, Nemours Bldg.
Wilmington 98, Delaware

Please send FREE booklet describing the advantages of floor wax with "Ludox" and a list of suppliers of these quality waxes.

*Name*_____

*Firm*_____ *Title*_____

*Address*_____

*City*_____ *State*_____

Non-Marking Furniture Glide Has Nylon Base

Bassick announces the development of a tilting furniture glide similar to its steel-based model but made of durable nylon.

The new glide protects floors and floor coverings from stains, marks, rust or corrosion, and is especially useful on carpets and resilient floor coverings. **The Bassick Co., 3043 Fairfield Ave., Bridgeport 5, Conn.**

For more details circle #788 on mailing card.

Super Tough Magnetic Tape in "Scotch" Brand No. 311

The new "Scotch" Brand No. 311 magnetic tape with Tenzar backing is a super tough product designed for rugged use conditions, including frequent repeat, continuous play and constant handling. It is tear and stretch-resistant, non-drying and free-running, yet compares in price with standard recording tapes and has uniform, high potency oxides for brilliant sound reproduction and full-range frequency response. The patented Silicone Lubrication impregnated throughout the entire coating assures effective, lasting protection for recorder heads. **Minnesota Mining & Mfg. Co., Magnetic Products Div., 900 Bush St., St. Paul 6, Minn.**

For more details circle #789 on mailing card.

Tomac Chrome Commode Has White Seat and Cover

A standard size and height toilet seat with white enamel finish and hinged cover makes the Tomac non-folding commode comfortable for the patient. Any standard bed pan or deep pail may be used with the commode and is held securely with a unique spring attachment, yet is easily removed for emptying and cleaning. The chrome-plated commode features Dynalok construction for maximum rigidity and

wear. Continuous one-inch steel tubing forms arm rests for patient support and for ease in carrying. The legs have rubber crutch tips and a rubber bumper protects the seat when raised. **Hospital Supply Div., American Hospital Supply Corp., Evanston, Ill.**

For more details circle #790 on mailing card.

Space-Saving Flask for Laboratory Sciences

Especially designed to take up less area and pack more closely on shelves, in refrigerators and cabinets, the new Kimble square-shaped, volumetric flasks come in five sizes and are manufactured from Kimble KG-33 borosilicate glass. Containing all of the qualities found in Kimble's hard glass line, including durability, stability and resistance to thermal shock and chemical attack, the new square flasks meet National Bureau of Standards specifications. **Kimble Glass Co., sub. of Owens-Illinois, Toledo 1, Ohio.**

For more details circle #791 on mailing card.

Specially Designed "Magic Lids" Convert Drums to Waste Receptacles

Bolting, screwing or other adapter devices are eliminated with the use of "Magic Lids" designed to convert 16-gallon drums into waste receptacles. The lid is automatically locked over the drum rim when the long arc-shaped handle, which ensures proper balance for lifting and carrying, is raised. A center hole simplifies waste disposal. **United Metal Cabinet Corp., 8 E. 36th St., New York 16.**

For more details circle #792 on mailing card.

(Continued on page 232)

The BURGESS-MANNING 3-WAY FUNCTIONAL CEILING

No OTHER HEATING and COOLING SYSTEM SO COMPLETELY SATISFIES the HOSPITAL NEED

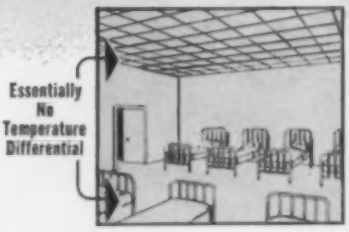
These basic 6 Points of Superiority

1. Maximum Comfort
2. Operating Economy
3. Maintenance Economy
4. Acoustical Efficiency
5. Attractive Appearance
6. Structural Simplicity

have raised the standard of comfort conditioning and provided many "plus" economies

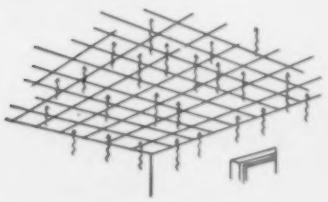
TEMPERATURES UNIFORM THROUGHOUT ROOM

Burgess-Manning Radiant Acoustical Ceiling heating assures uniform temperatures in all parts of the room, from floor to ceiling. Even adjacent to windows, there are no cold or hot areas to aggravate patients or induce colds.



FLOORS ARE ALWAYS WARM

Warm floors are important for mentally disturbed patients, as well as for children. Almost every room floor receives the largest part of the radiant energy emitted from Burgess-Manning Radiant ceiling heat — rarely accomplished by other old types of heating.



COOLING IS EQUALLY EFFICIENT

The Burgess-Manning Radiant Acoustical Ceiling operates in reverse on the cooling cycle. The cool water, circulated in the coils, absorbs radiant energy from the room, thus reducing the sensible heat of the room.

When you *specify* and *install* the Burgess-Manning Radiant Acoustical Ceiling for hospital and institutional heating, cooling and acoustical control . . . you have the highest efficiency in comfort conditioning . . . with greatest design flexibility in installation, and economy in operation and maintenance.

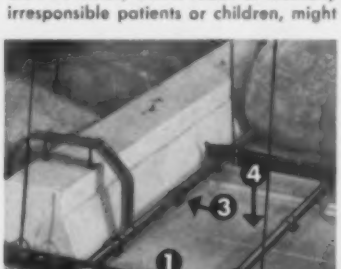
This completely dependable, versatile method of radiant heating, cooling and sound reduction has proven itself in hospitals and institutions . . . it is efficient, easily controlled radiant panel heating and cooling with desirable noise control for maximum human comfort.

For the psychiatric or children's hospital, the Burgess-Manning Radiant Acoustical Ceiling eliminates hot radiators, baseboard convectors and registers, etc . . . which, within reach of mentally irresponsible patients or children, might prove harmful. Thermostats are accessibly placed for authorized personnel use only.

Providing an entirely new standard for comfort in living and working quarters, not only does the Burgess-Manning Ceiling *heat, cool and quiet* in one unit, but its pleasing architectural appearance, standard installation methods and maintenance assure a long-range economy not possible with other old types of heating. Important, too, it operates with standard hot water heating or water chilling equipment, using standard controls.

Specify the Burgess-Manning Radiant Acoustical Ceiling to create comfortable environments for patient and worker; provide uniform radiant heating, uniform radiant cooling, and uniform sound absorption; give complete satisfaction; and insure low operating and maintenance costs.

The complete story of the Burgess-Manning Radiant Acoustical Ceiling, together with specifications and other valuable data, is yours by writing for Bulletin No. 138-3 . . . sent without obligation.



1. **Header**—Prefabricated 1½" square tubing. (ASTM A-120 test)
2. **Coil Spring Clip**—Holds coil on suspension channels. Black oxide finish.
3. **Panel Spring Clips**—Hold snap-on aluminum panels on coil. Black oxide finish.
4. **Snap-on Aluminum Panel**—Finished with two coats of baked-on white enamel.

3 Heating Cooling Acoustical

BURGESS-MANNING COMPANY

Architectural Products Division

721 East Park Ave. Libertyville, Ill.

For additional information, use postcard facing back cover.

Shelf-Filing Facilitated With Mobile Work Station

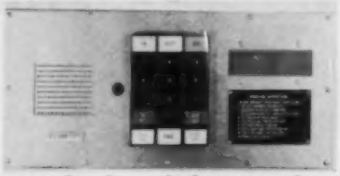
The Mobile Shelf Filing Truck is a self-contained work station for use with all makes of shelf-filing. With the mobile unit an operator can handle correspondence both to be filed and to be pulled from shelves as one combined operation, and the step-stool platform permits easy reach to top shelves. Correspondence or

folders to be filed are held in either letter or legal-size width Flexifiles in a bin at the top of the truck. A large compartment below the bin with three vertical dividers takes folders removed from the file and another large compartment carries blank folders, guides and other supplies. The platform automatically seals to the floor when the operator stands, then restores to casters for mobility. It rolls easily on two swivel and two fixed casters and is surrounded by rubber bumpers. **Remington Rand Div., Sperry Rand Corp., 315 Park Ave., New York 10.**

For more details circle #793 on mailing card.

Compact, Automatic System for Audio-Visual In-Out Register

Capable of registering up to 1000 persons, the new Executone Audio-Visual In-Out Register System combines the advanced features of the company's two-way intercom with the advantages of visual register. Consisting of three major units, the system uses a pre-assigned identifica-



tion number for each doctor or other individual, who registers his number by operating the Recorder Panel at one of the entrances. The doctor observes his number as it lights on the Recorder Panel and can check against error. Pre-received messages cause his light to pulsate, indicating a message, and he speaks with the operator over the intercom at the Recorder Panel to receive it. Information on staff members is available through the message center or by operating one of the Recorder Panels. Other features make the system flexible and encompassing, and added facilities such as Auxiliary Panels and independent Executone Intercom Staff Stations are also available. **Executone, Inc., Hospital Div., 415 Lexington Ave., New York 17.**

For more details circle #794 on mailing card.

Continuous Line Grille Has Adjustable Core

Model STWA is a new Continuous Line Diffusing Grille in the Uni-Flo line of air distribution products. It can be mounted in ceiling, floor, sill or side wall by a simplified spring clip fastener for easy installation. The new grille has an adjustable core for changing air patterns through a tam-

perproof setting of the fins. The vertical air pattern can be altered up or down by inverting the grille, which features a sturdy flat aluminum flange. **Barber-Colman Co., 1300 Rock St., Rockford, Ill.**

For more details circle #795 on mailing card.

Portable Collator for Manual Operation

Up to 6000 pages can be assembled per hour with the new compact, lightweight Heinz Portable Collator. Developed for use where large mechanical equipment is

not required, the new collator is inexpensive and incorporates a new principle in manual paper gathering technic. Simple, quick two-handed operation permits fast collation of up to 12 sheets. Speed comparable to mechanical collation can be achieved even by unskilled operators. Each of the 12 stations holds 300 sheets of 20-pound paper in sizes up to 17 by 11 inches. **A. P. Heinz Co., 2422 Lunt Ave., Chicago 45.**

For more details circle #796 on mailing card.

Polycrystalline Ceramic Transmits Light

Polycrystalline ceramic that readily transmits light and is made from powders is a new material developed by General Electric. It also possesses the extremely high strength characteristic of alumina ceramics, according to the report, can withstand higher temperatures than most ceramics, and can be pressed into any desired shape. Called Lucalox, the new material is described as having the composition of a ceramic, the structure of a metal, and light-transmitting ability approaching that of glass. **General Electric, Schenectady, N.Y.**

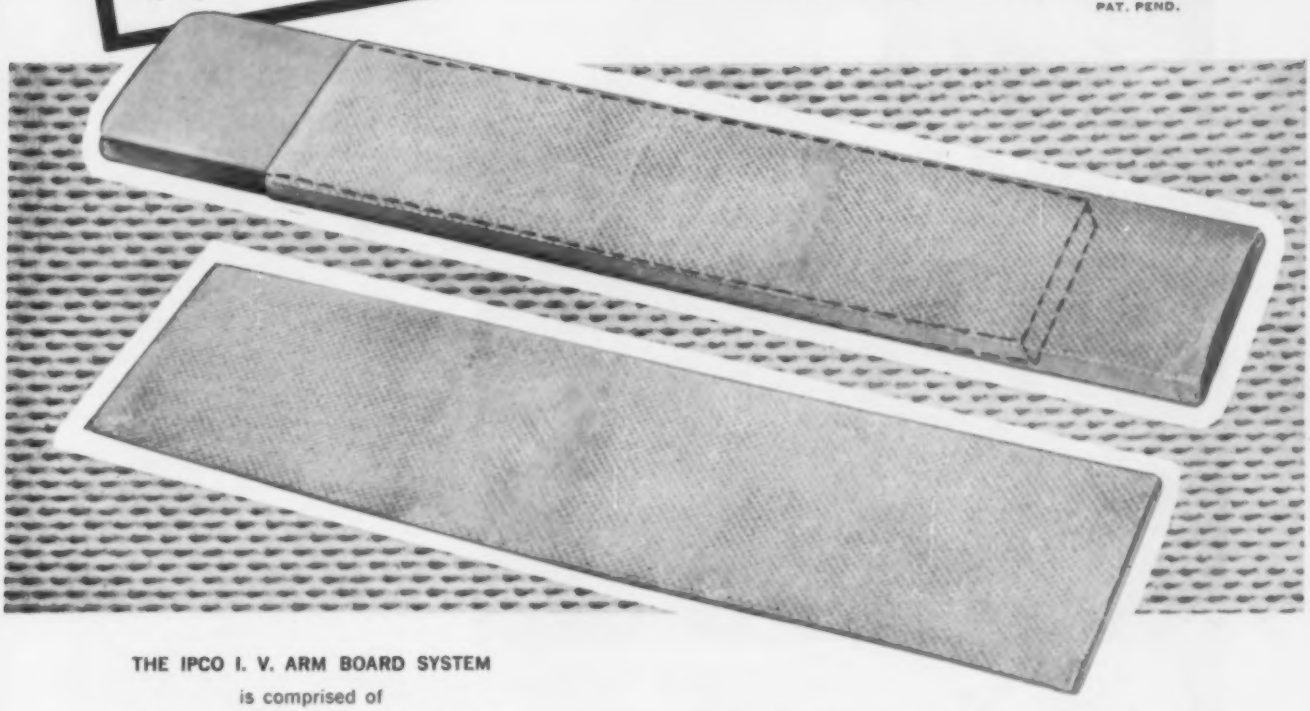
For more details circle #797 on mailing card.

(Continued on page 234)

SOLVED . . .
another
hospital problem

ipco I.V. ARM BOARD SYSTEM

PAT. PEND.



THE IPCO I. V. ARM BOARD SYSTEM

is comprised of

► **CUSHION BOARD** of soft, polyurethane foam bonded to a basswood splint core. Entire board encased in heat-sealed vinyl. PLUS,

► **DISPOSABLE DURA-WEVE® SLEEVE**

this combination provides:

A reusable, easily cleaned board

Complete adaptation to normal procedure

Greater utility with no time loss in the preparation of arm boards

Greater patient-comfort since Dura-Weve® absorptive qualities help prevent irritation

One time use of sleeve for each patient aids materially in controlling cross infection

*PRODUCT OF SCOTT PAPER CO.

An effective method to immobilize patient's arm in the administration of intravenous solutions — thus abolishing the need for materials and time spent in preparing makeshift arm boards. The IPCO I.V. Arm Board System provides a comfortable, unified, economical prop in accord with today's most modern technique.

► **FREE SAMPLES AVAILABLE UPON REQUEST** ◄

HE-616 I.V. Arm Board		HE-616X I.V. Arm Board	
18" LONG		9" LONG	
6	$ 1.35 ea.	6	$ 1.20 ea.
1 doz.	13.95 doz.	1 doz.	12.75 doz.
3 doz.	12.95 doz.	3 doz.	11.75 doz.
6 doz.	11.95 doz.	6 doz.	10.75 doz.
(Minimum Order—6)			

HE-616A Dura-Weve® Sleeve for I.V. Arm Board		HE-616AX Dura-Weve® Sleeve for I.V. Arm Board	
18" LONG (300 per case)		9" LONG (600 per case)	
100	$8.45 C	100	$4.45 C
300 (case)	7.75 C	300	4.25 C
600 (2 cases)	7.45 C	600 (case)	3.95 C
(Minimum Order—100)			

NOTE: Please write for information and prices on conductive rubber covers for Arm Boards for use in O.R.

a complete source for hospital supplies and equipment

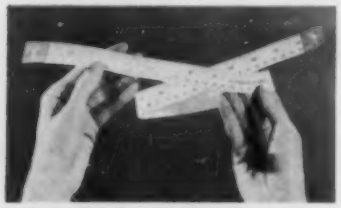
ipco HOSPITAL SUPPLY CORP.

161 SIXTH AVENUE • NEW YORK 13, N. Y.

OTHER OFFICES: CHICAGO 45, ILL., DALLAS 7, TEXAS

Baby Measuring Tape Priced for Disposability

Packaged in boxes of 250, the new Disposable Baby Tape provides means for



safe measuring of infants at birth. It is made of sturdy moisture-resistant paper which is autoclavable and can be personalized with the hospital name, city and state. Space is provided for recording birth information and infant growth when the tape is given to parents as a hospital memento. The tape is marked in centimeters and inches and is 26 inches long. It is also useful in any department where a soft, non-metallic measure is desired. **Hollister Incorporated, 833 N. Orleans St., Chicago 10.**

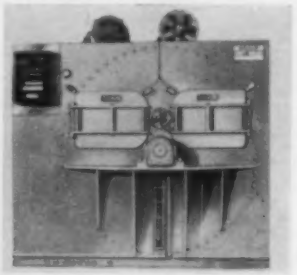
For more details circle #798 on mailing card.

Rollfilm Processor for Cineradiographic Facilities

The Picker-Smith Rollfilm Processor handles eight, 16, 35 and 70mm cineradiography rollfilm, providing the radiologist with a means of developing cinefilms and making them available almost immediately. The mobile processor, 15 inches wide and 3½ feet long, can be set up for operation in less than five minutes at any location with an ordinary electrical outlet and a sink for water supply and drain. More economical than commercial processing, the unit can also be used to develop photofluorographic film from chest x-ray units or any rollfilm up to 70mm. **Picker X-Ray Corp., 25 S. Broadway, White Plains, N.Y.**

For more details circle #799 on mailing card.

Braun Unit Wash Speeds Laundry Operation



The compact, space-saving Braun Unit Wash now available in a 600-pound size combines washer, extractor and shakeout in one machine. It processes an entire load in approximately 45 minutes, depending upon the type of work. The specially designed four-pocket 72-inch diameter cylinder assures high quality work with minimum tensile strength loss, reducing mending costs. The 600-pound machine is designed so that two persons can load or unload netted work in eight minutes and un-netted work in twelve minutes. With two outer doors on the Unit Wash, the cylinder requires only one re-positioning for loading or unloading. **G. A. Braun, Inc., 461 E. Brighton Ave., Syracuse 5, N.Y.**

For more details circle #800 on mailing card.

Booksize Anatomical Chart Shows Male and Female

Printed in Western Germany, the "Minder" booksize anatomical chart is

now available in the United States. The manikin shows the male and female body with explanatory index attached. Eight individual color plates, 15 inches high, show front and rear views of body, skeleton, muscles, nervous system and blood circulation. Illustrations of body organs are pictured in an overlapping manner to be seen from front or back. **Otto Marschuetz, Importer, 3141 Sheffield Ave., Chicago 14.**

For more details circle #801 on mailing card.

(Continued on page 236)

Hospital personnel, too, need TENDER LOVING CARE

You can help your nursing staff save *miles* of needless walking and *hours* of wasted time by giving them modern DuKane Audio-Visual Nurses' Call equipment. This most advanced hospital communications system has many exclusive nurse-saver features. For example, 12 critical patients can be "visited" every two minutes... *Automatically.* Learn the complete story in 9 minutes by seeing our new color sound film.

DuKane
CORPORATION

DuKane products are sold and serviced by a nation-wide network of factory-trained engineering distributors.

Dept. MH 50, DuKane Corporation, St. Charles, Illinois
Please tell us more about DuKane's Audio Visual Nurses' Call Equipment.

Name_____ Title_____

Institution_____

City_____ Zone___ State_____

For additional information, use postcard facing back cover.

Economy Model Photocopier Is Compact Desk Unit

A compact desk top photocopying machine is now available at a price to permit

placement of models in several locations. Model 101 will make black on white copies of letters, reports and other material typed or handwritten in pencil, ink or crayon, and reproduces rubber stamps, date stamps and other notations. The permanent copies do not fade due to age, heat or light. Model 101 will copy material up to nine inches wide and of legal size length quickly and easily, and features the Multicopy process for making extra copies when needed. **A. B. Dick Co., 5700 W. Touhy Ave., Chicago 48.**

For more details circle #802 on mailing card.

Pressure-Electric Switch for Gradual Heat Control

A new pressure-electric switch, called the MS (Multi-Step) Switch, is introduced to provide smooth, gradual control of electric heat unit ventilators in various types of institutions. It uses a variable pneumatic signal to actuate as many as ten electric heating elements in sequence for the temperature level required. The switch can be mounted on or away from the unit ventilator, and individual switches are replaceable without moving or disconnecting any other switch or part. The MS Switch provides an economical means of achieving variations in temperature with electric heat. **The Powers Regulator Co., 3434 Oakton St., Skokie, Ill.**

For more details circle #803 on mailing card.

Model 790 Glass Washer Is Flexible and Rapid

Glassware, containers and metal ware are cleaned quickly and efficiently in the new Model 790 glassware and container washing machine. Designed for use in central supply and in the laboratory, the machine combines the best features of water jet machines with the rapid soil removal advantages of power driven spinning brushes. Of all stainless steel construction, the Model 790 has a brush section with seven spinning vari-speed brushes and wet-brush-drill for instant removal of heavy soils. The complete kit of interchangeable brushes will handle pieces as small as 8mm tubes or 2cc syringes up to large containers and long cylinders. A 24-

inch square jet compartment with three-cycle operation to provide an automatic timed detergent wash and tap water and distilled water rinses, removes both light soils and film. Heavy duty pumps and a new jet principle materially shorten the time for perfect cleaning of an entire rack of glassware. The washer occupies only 30 by 54 inches of floor space. **Southern Cross Mfg. Corp., Chambersburg, Pa.**

For more details circle #804 on mailing card.

Ten-Inch Wall Tile Now Available in Formica

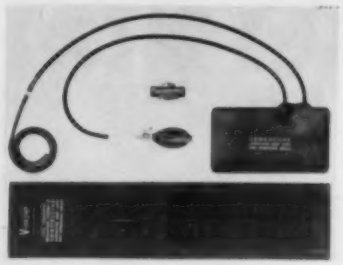
Walls in washrooms, corridors and other areas where an impervious surface and attractive appearance are desirable can now be covered with the new Formica Wall Tile. The material comes in ten-inch squares and is flexible enough for butting together for uniform seams. Packaged 50 tiles to a box, six boxes to a carton, Formica Wall Tile is applied with Formica Fast Dry Contact Bond cement to plaster at least 30 days old, or with Formica Wall Tile Adhesive to dry wall or plywood. The new product has the durability of Formica and is available in eight colors and patterns and three wood grains. **Formica Corporation, Cincinnati, Ohio.**

For more details circle #805 on mailing card.

(Continued on page 238)

Conductive V-Lok Inflation System on Baumanometer

Developed to reduce operating room hazards, every component of the Baumanometer Conductive V-Lok Inflation System is fully tested and approved safe for



use in anesthetizing areas. The V-Lok Cuff is made of finely woven fabric coated on both surfaces with conductive neoprene and utilizing the new Velcro nonmetallic closure. Bulb, bag and tubing are all seamless, dipped conductive latex, including extra length conductive latex tubing and Air-Flo Control Valve. The system can be used with any bloodpressure instrument. **W. A. Baum Co., Copiague, N.Y.**

For more details circle #806 on mailing card.

Coffee Dispensing Machine Brews Fresh Cup Automatically

A new vending machine that brews each individual cup of coffee from ground coffee beans, filters the brew and serves it fresh with cream and sugar or black, is available in the "Brew-A-Cup." Research and development work on the machine and the coffee used has been under way for five years. A measured amount of carefully selected ground coffee is packed between

two layers of filter material. As the machine is operated, a new pack, sufficient for one cup, comes into place to be brewed in six seconds by the automatic mechanism. **Rudd-Melikian, Inc., Hatboro, Pa.**

For more details circle #807 on mailing card.

Non-Burning Hot Water Bottle Requires No Filling

The "No-Burn" Hot Water Bottle Heating Unit provides a constant supply of bottles ready for use. Permanently sealed, leakproof bottles are kept at the desired pre-determined temperature in a hydrostatically controlled "bath" which is connected to the regular water system. Made of standard material and in standard size, the hot water bottles have no screw caps or rigid knobs. Nurses and aids are protected from the possibility of discomfort or burns and saved the considerable time which would be spent in refilling with hot water. **National Cylinder Gas Div., Chemetron Corp., 840 N. Michigan Ave., Chicago 1.**

For more details circle #808 on mailing card.

Erecta-Shelf for Storage Lets in Light and Air

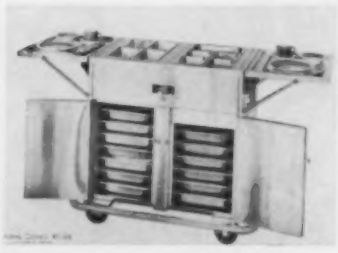
Wide, unobstructed shelves for linen storage as well as other supplies are provided in Erecta-Shelf. The open steel rod construction permits circulation of light and air to keep stored linens fresh. Shelves are 18 inches deep and identifying tags can be snapped into the fronts for efficiency in handling and quick identification. Erecta-Shelf assembles quickly without nuts, bolts or special tools and it adapts to practically any desired size or shape, with additions easily made in any

direction for increased storage facilities. **Metropolitan Wire Goods Corp., N. Washington & George, Wilkes-Barre, Pa.**

For more details circle #809 on mailing card.

New Portable Electric Cart Transports Hot and Cold Foods

Versatility is a feature of the new Atlas Model 572 Portable Electric Hot and Cold Food Cart which contains three compartments, each controlled by a separate electric thermostat. The new, advanced design "cold-conditioned" food compartment and two heat compartments, one with dry or moist and one with dry heat, maintain hot or cold foods at desired temperatures, solving the problems of handling varied menus and special diets. Designed to transport and serve foods in hospitals and other institutions where persons to be fed are remote from the food preparation center, the mobile,



self-contained unit may be plugged into any standard electric outlet and serves complete meals for 300 children or 175 adults. **National Cornice Works, Atlas Div., 1323 Channing St., Los Angeles 21, Calif.**

For more details circle #810 on mailing card.

(Continued on page 240)

NEW! IMPROVED!

EASY TO FASTEN
Handy fastening at shoulder — can be fastened from front—even by patient!

Angelica's V-Grip* Patient Gown with VELCRO® CLOSURE

NO TAPES! NO KNOTS! NO GRIPPERS!

NEW PATIENT COMFORT

Patients will enjoy new comfort, in this new gown that has no bulky knots or tapes to irritate, chafe or annoy. A two square inch patch of Velcro, the amazing nylon fastening material, takes the place of tapes. The patient feels no bulk—the gown closes securely—stays closed with no gap.

SUPERVISORS APPROVE

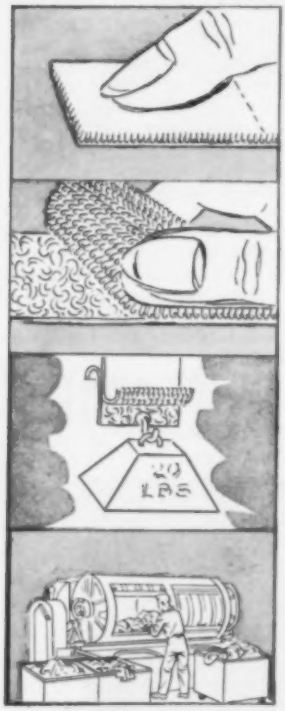
Nurses save time and energy when their patients are comfortable and quiet. Angelica "V-Grip" patient gowns mean fewer nurse calls, fewer bed and bedding adjustments. Velcro never touches patient's skin when closed. It all adds up to more time for nurses, healthful rest for patients.

HOUSEKEEPERS SAVE WORK

Say goodbye to tape repair and extra trips to the linen shelves to replace torn gowns. Because Velcro fasteners are flat and stitched on all four sides, they can't come loose. When you buy the tapeless V-Grip gown you eliminate the biggest cause of repairs.

TESTED IN USE

Angelica "V-Grip" Patient Gowns have been tested in actual hospital use. They have been hospital laundered repeatedly—mangled—have undergone rigorous trials and laundry tests on commercial equipment.



PRESS SHUT
Gentle Finger pressure closes Velcro securely—stays closed.

PEEL OPEN
The two Velcro surfaces separate easily when "peeled" from the edge.

STRONG
Velcro resists strong lateral strain—won't come open in normal wear.

NORMAL LAUNDERING
Washes with other laundry—tumble dried—flatwork finished
NOT TO BE PRESSED OR IRONED

*T. M. Reg.

Ask For A Demonstration Today. You'll be amazed at the simplicity and strength of this revolutionary new fastening material. A simple demonstration will show you how Angelica's V-Grip can cut dollars from laundry and repair bills, add to patient comfort, ease work load of nurses and housekeepers. Clip the Coupon and Send it in Today—For Free Demonstration-

ANGELICA UNIFORM CO.
(Address to nearest office)

1427 Olive St., St. Louis 3, Mo.
107 W. 48th St., New York 36, N.Y.
177 N. Michigan Ave., Chicago 1, Ill.
1900 W. Pico Blvd., Los Angeles 6, Calif.

We're Interested! Ask your representative to contact us at once to arrange a demonstration of Angelica's new patient gown with Velcro, the Magic Fastener.

Hospital_____

City & State _____

Name _____

Title _____

Angelica® UNIFORMS

1427 Olive St., St. Louis 3, Mo.
107 W. 48th St., New York 36, N.Y.
177 N. Michigan Ave., Chicago 1, Ill.
1900 W. Pico Blvd., Los Angeles 6, Calif.

For additional information, use postcard facing back cover.

Automatic Roasting Controls Put Automation in Cooking

Better roasts with increased servings per pound are assured with the automatic roasting controls developed by Minneapolis-Honeywell. An ElectroniK strip chart recorder monitors oven temperatures when the automatic controls are set, providing a permanent record of oven performance. Overcooking, with subsequent waste, is prevented as an alarm sounds when the desired internal meat temperature is reached, and a light remains on the control panel until the temperature-sensing element inside the oven is disconnected. **Minneapolis-Honeywell, Brown Instrument Div., Wayne & Windrim Ave., Philadelphia, Pa.**

For more details circle #811 on mailing card.

"Forward" Cleaning Chemical Is Safe on Washable Surfaces

Compounded to solve the most difficult cleaning problems, "Forward" cleaning chemical solution is safe for all washable surfaces, including floors, ceilings, walls, furniture, heating and lighting fixtures and other equipment, and particularly terrazzo. Because it contains a sanitizing agent that reduces bacterial count to safe levels, it is especially useful for cleaning washbowls and other plumbing in public as well as patient facilities. It has an exceptionally high alkaline cleaning power, but is silicate-buffered for safety. The balanced formula resists the neutralizing action of dirt, thus there is no fade-out of cleaning power when mop or sponge transfers dirt to the cleaning solution. **S. C. Johnson & Son, Inc., Racine, Wis.**

For more details circle #812 on mailing card.

Emergency Oxygen Supply in Portable Lif-O-Gen Unit

Providing approximately seven gallons of pure gaseous oxygen for emergency use, the Lif-O-Gen oxygen unit is compact in size and weighs only 20 ounces. It is easy to use, permitting oxygen to be administered instantly by merely pressing a pushbutton on the top of the container. A disposable face mask is included with the unit for attaching to the outlet if desired. Oxygen flow can be administered intermittently or continuously and the container is disposable when empty. **Linde Co., Div. of Union Carbide Corp., 420 Lexington Ave., New York 17.**

For more details circle #813 on mailing card.

Wall-Tite Water Cooler Is Modern in Design

The modern design of the Halsey Taylor Wall-Tite Water Cooler conceals plumbing, saves floor space since the unit fits snugly against the wall, and facilitates installation. The Wall-Tite is available in six, 11 or 16-gallon capacities, stands 40 inches high and extends 13 inches from the wall. Its stainless steel top has a fully-contoured, splash-resistant basin and wall protective shield. **Halsey W. Taylor Co., Warren, Ohio.**

For more details circle #814 on mailing card.

(Continued on page 242)

from the ground UP Colson® builds it better...

For all 'round usefulness, nothing beats the quality or the versatility of the new, low-cost Servette Cart by Colson. It provides the perfect answer to fast, efficient meal distribution, serving, or clean-up. Its crevice-free design includes features found in carts costing much more. The unit has three 18x27-inch stainless steel shelves, beveled for easy removal of trays and quick cleaning. Frame is *tubular*, and chromium plated. Colson quality casters make the unit roll smoothly and respond to the touch. So attractive and neat, it can be used in the dining room as well as kitchen.

INTRODUCING NEW CAN CARRY-ALL DOLLY

The new Can Carry-All Dolly by Colson now makes it practical to put wheels under all cans and drums. Unusually low in cost, with many fine features. Constructed of rugged, flat steel cross supports and Colson plate casters. Available in three models: with 2-inch casters, 3-inch casters, and a unit that handle loads up to 300 pounds. Designed specifically to move supply or refuse cans up to 18, 20 or 24 inches in diameter. A real work saver, rugged, smooth rolling . . . and so inexpensive you can mobilize at the lowest cost possible, and still get the quality Colson is famous for.

SEND FOR FREE LITERATURE and a catalog of dozens of items for servicing and maintenance.

COLSON'S 75th YEAR OF PROGRESS

75 years of experience in supplying field-tested equipment and casters to industry and institutions. Millions of satisfied customers know and respect the name COLSON . . . synonym for quality.

THE COLSON CORPORATION 7 S. Dearborn Street
Plants in: Jonesboro, Ark.; Sommerville, Mass. and Elyria, Ohio CHICAGO, ILLINOIS

Nine Improved Vacuum Cleaners In Multi-Clean Line

Exclusive features built into the nine new Imperial Vacuum Cleaners in the Multi-Clean line give them an attractive appearance, together with efficient operation. The patented, pleated, washable filter used in the machines is made from a special synthetic fiber that does not rot or mildew, and provides more than 1400 square inches of filter area. It can be washed, rinsed and quickly dripped-dry. The line consists of three series: the

Imperial "3," powered by a ½ h.p. motor; the "10" with a one h.p. motor, and the "15" with a 1½ h.p. motor. Each is available with 7, 12 and 17-gallon tanks in either heavy gauge stainless steel or standard seamless steel with baked enamel finish. **Multi-Clean Products, Inc., 2277 Ford Pkwy., St. Paul 16, Minn.**

For more details circle #815 on mailing card.

Conveyor Dishwasher in Compact 60-Inch Machine

Compact, two-tank units only 60 inches long are now available in the Toledo Conveyor Dishwasher series. They are designed for maximum efficiency in kitchens where space is limited, and handle up to 4805 dishes per hour. Model 2T-P-60R has a pre-wash pump which recirculates

water from the final rinse overflow. Model 2T-P-60 is equipped with a fresh water pre-wash. The Panoramic Door gives an unobstructed view of the interior and full access to all inside parts. The units are of stainless steel and corrosion-resistant construction. **Toledo Scale Corp., Kitchen Machines Div., 245 Hollenbeck St., Rochester, N.Y.**

For more details circle #816 on mailing card.

Lightweight Dolly Provides "On-Wheels" Storage

Weighing only 9½ pounds, the Model 863-LW Dolly eliminates noise and wear in handling food, maintenance supply and other large containers by providing "on-wheels" storage, ready for instant transport. Easily hand carried, the circular dolly, with a recommended capacity of 300 pounds, has a cross-braced, one-piece, smoothly finished steel frame, four swivel casters and solid rubber wheels. **Nutting Truck & Caster Co., 1201 W. Division St., Fairbault, Minn.**

For more details circle #817 on mailing card.

Attractive Space Dividers Provided in FiliGrille

FiliGrille is a new grillework in standard designs, factory-fabricated in customized panels, and engineered for simple and economical installation as space dividers and screens in entryways, cafeterias, solariums and other areas. Made of ¾-inch polystyrene in a frame of anodized aluminum, the attractive and useful grillework has a standard white finish but can also be factory painted in colors or metallics as desired. **Holcomb & Hoke Mfg. Co., Inc., Dept. 811, 1545 Van Buren St., Indianapolis 7, Ind.**

For more details circle #818 on mailing card.

(Continued on page 244)

new McKesson

'1200' absorber

sets new high standard for compactness and efficiency . . . and will fit any regular anesthesia unit!

Several salient features of the new McKesson **'1200' ABSORBER**

- twin vertical reversible *acrylic* canister instantly removable by loosening single clamp screw
- screens easily removed by loosening bayonet-type connection
- newly-designed silicone-rubber valves have low adhesion properties, are extremely quiet in use, and seal perfectly
- valves mounted in acrylic caps, instantly removable without tools
- provides 30 to 40 hours of absorption . . . extremely low resistance to respiration

McKesson '1200' ABSORBER

Write for '1200' Absorber Brochure. This complete information is yours for the asking by letter or postcard.

McKESSON APPLIANCE COMPANY • TOLEDO 10, OHIO

For additional information, use postcard facing back cover.

High Style Institutional Ware Developed by Corning

Decor Dinnerware is a new line of high style institutional ware with a classic, white floral pattern against a band of color. The new ware is made of the same lightweight durable materials as existing products in the Pyrex brand Double-Tough dinnerware line and is available in all 22 pieces of Corning institutional dinnerware. There are three varieties; Revel, Bluegrass and Grecian, in tones of coral, aqua and gray. New in Corning dinnerware is a universal stacking saucer which fits snugly into the top of a coffee cup so that several cups and saucers can be safely stacked. **Corning Glass Works, Corning, N.Y.**

For more details circle #819 on mailing card.

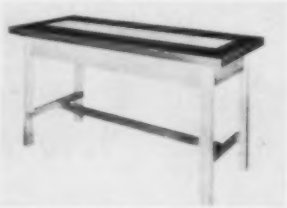
Dolly Moves Cans up to 20 Inches in Diameter

"Colson's Can Carry-All," a low-cost, portable steel dolly with a weight capacity of 300 pounds, assures quick and easy movement of cumbersome material and can be used in institutional kitchens and maintenance and supply rooms. The dolly, designed to move supply or refuse cans up to 20 inches in diameter, is constructed with cadmium plated hard rolled steel cross members and Colson plate casters with two or three-inch wheels. **Colson Corp., 7 S. Dearborn St., Chicago 3.**

For more details circle #820 on mailing card.

Linen Inspection Table Has Shatterproof Glass

A flush mounted center section of translucent, shatterproof glass illuminated



from underneath by two 40-watt fluorescent lamps provides an efficient area for linen inspection. The Austin Vu-Master table speeds examination of linens to discover pinholes, thin areas and flaws resulting from towel clamps and other damaging equipment. The 24 by 60-inch top has a Masonite border providing a completely smooth surface with no possibility of splinters, thus speeding the safe inspection of linens of all types in the hospital. **Austin Supply Co., 210 S. Clinton St., Chicago 6.**

For more details circle #821 on mailing card.

Heavy Duty Lounge Furniture in Attractive Domino Line

Flexibility, modern styling and heavy duty construction with lightness of appearance are built into the attractive new Domino line of tables and seating. Modular in design, the components can be combined to fit any space and in any arrangement required. Sturdy frames of common design are available in 36, 48, 60, 72, 96 and 120-

inch sizes for combining with seating and table units in straight-line or corner arrangements. The steel frames are welded, one-piece units of great strength, finished in white, turquoise, black or copper mist. Seating units are cushioned with foam rubber supported by heavy gauge No-Sag springs, covered with durable Doe-Vin, Nylon or Nylo-Saran fabrics in a choice of colors. Table tops are of reinforced Fiberesin plastic, self-edged, in white cork, cherry or American walnut finish. The line is suitable for patients and doctors lounges, waiting rooms, nurses homes and other areas. **The Troy Sunshade Co., Troy 1, Ohio.**

For more details circle #822 on mailing card.

(Continued on page 248)

"Oh no... not another compress..."

I've got three of them already. "What in the world has happened to progress?" Steady, girl... steady. Maybe it's not too awfully bad. Maybe it needs just a little pad. "Complete leg and thigh? Two of them?" Well, this day is certainly shot—these things should be condemned... I'll surely be if they're not. "Why in the world don't they get something new? You say there is? We have? We do?"

aquamatic K *pad*

The flexible pad laced gently into place, holds in the moisture, restricting evaporation. Constant heat with temperatures always within 1°F. Just check the compress about every few hours. Time saved has been measured at an almost unbelievable 86%. Pads in several sizes. Comfortable. Light in weight, not bulky. Whisper quiet control unit stays on bedside table. For complete information and test data, write: Gorman-Rupp Industries, Inc. or ask your American Hospital Supply Corp. representative.

GORMAN-RUPP INDUSTRIES, INC., BELLVILLE, OHIO

DISTRIBUTED NATIONALLY BY { American Hospital Supply Corporation and V. Mueller and Company

For additional information, use postcard facing back cover.

Only Carrier offers icemakers with certified capacity

Carrier offers 16 ice machines for cubes, crushed, flakes or chips, each with its capacity certified in writing. Not "average production," or "up to," but actual capacity, based on summer temperatures in your area. Nobody else gives you this protection.

You can save up to 80% on ice with a Carrier Icemaker. For facts and figures, call your Carrier dealer, listed in the Yellow Pages under Ice Making Equipment. Or, write to Carrier Corporation, Syracuse 1, New York.

Carrier AIR CONDITIONING REFRIGERATION

Bally walk-ins

Aluminum or steel sectional construction

Sanitary! Strong! Efficient! You can assemble any size cooler, freezer or combination in any shape from standard sections. Add sections to increase size as your requirements grow. Easy to disassemble for relocation.

Bally Case and Cooler, Inc., Bally, Pa.

Get details — write MH-5 for FREE book.

Hospitals, Hotels, praise

JIFFYWHITE TOILET BOWL CLEANER

FREE! MOP with EACH QUART

Stains, dirt, and even grease disappear instantly like magic! Clean your toilet bowls with this new sudsing action way . . . it's so much easier and convenient.

JIFFYWHITE has many other uses . . . CLEANS URINAL JARS and PANS INSTANTLY, cleans stains from porcelain, ceramic tile walls and floors, shower stalls, swimming pools, etc.

- *Harmless to Porcelain and Septic Tanks*
- *Results Guaranteed*
- *Easy on the Hands.*

Ask your supply man for a FREE full quart sample with mop or write:

VINCE B. NYHAN CO.

1300 S. CANAL STREET CHICAGO 7, ILLINOIS

Wet Tray Caddy Permits Complete Drying

Proper drainage and drying of hot, wet trays is assured with the new Wet Tray Caddy, Model T-222. Trays are stacked on edge on the sloped top shelf as they are taken from the dishwasher. When dry, they may be transferred to the lower shelf

for flat stacking, permitting re-use of the top shelf for drying. The top shelf is easily removed for periodic cleaning and has a drain trough. Welded stainless steel construction and ball bearing swivel type casters with neoprene tires make the caddy sturdy and easy to handle. **Caddy Corporation of America, Secaucus, N.J.**

For more details circle #823 on mailing card.

Seven Colors Added to Tile Floor Line

The R.C.A. tile flooring is now available in seven new colors in medium tan, grays and blues. Four of the new colors are shown in the Flexi-Flor (Marbleized) line with three colors added in the Tara-Flor (Terrazzo) design. The rubber tile flooring is produced in rolls for ease of installation. **The R.C.A. Rubber Company, 1833 E. Market St., Akron 5, Ohio.**

For more details circle #824 on mailing card.

Dual-Purpose Labwasher Is Fully Automatic

Improvements built into the newly designed Dual-Purpose Labwasher include

optional distilled or tap water rinses, complete control of washing, rinsing, drying cycles through the selection of either automatic or manual control, corrosion-resistant pumping system, and free-sliding washing compartment for top loading and continuous working surface. It is designed for spotless cleaning of all types of laboratory glassware and a synchronized timer monitors each cycle. The Labwasher is a low-cost unit which is practically maintenance-free. **The Chemical Rubber Co., Special Products Div., 2310 Superior Ave., Cleveland 14, Ohio.**

For more details circle #825 on mailing card.

(Continued on page 250)

"No costly linen inventory is the main reason we recommend Linen Supply Service for Hospitals"

Mr. John W. Hay, president,
American Hospital Management Corporation *of Los Angeles*

New million dollar Southern California Dental Hospital now nearing completion. Managed by the American Hospital Management Corporation. Linen Supply Service by Community Linen Rental Service, Los Angeles.

"We have always recommended Linen Supply Service for the more than 50 hospitals where we have acted in a management or consultant capacity, and we will continue to do so. Our experience has consistently shown that the small cost involved is well worth the advantage of not having to maintain a linen inventory *which usually must be replaced every year*. Linen Supply also eliminates the many maintenance and personnel problems associated with hospital laundries." • Washable cotton uniforms, gowns, sheets . . . everything your hospital needs, supplied where and when you need it. Monies tied up in linen inventory and hospital equipment is freed for other uses. These are just a few of the benefits available to you through your local linen supplier. He is a specialist in service, and in the hygienic laundering of linens for hospitals. Find out how he can solve your many linen problems. Call your local linen supplier, today.

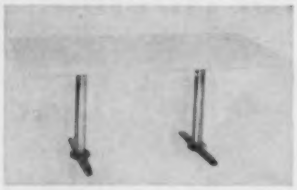
Look in the Yellow Pages under Linen or Towel Supply.

Note: No investment, no maintenance, no inventory. Everything is furnished and serviced by your local linen supplier, at low cost.

Linen Supply Association of America
and National Cotton Council • 22 West Monroe Street, Chicago 3, Illinois

Correlated Furniture Grouping for Institutional Food Service

Tables and chairs for cafeterias, dining rooms, lunchrooms and similar food service areas are included in the correlated group introduced by Howell. Table tops are of laminated plastic in colorful patterns designed especially for the new line, and the new style pedestal bases and legs harmonize with Howell chairs. Flexibility in planning room arrangements is permitted through the wide assortment of top styles, pedestal designs and sizes available. **The Howell Co., Contract Div., St. Charles, Ill.**



For more details circle #826 on mailing card.

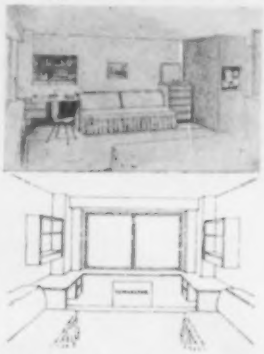
Hi-Q Silk Suture Is Strong and Smooth

Increased strength is "built-into" the new Champion Hi-Q Silk Sutures made by a unique process developed in Gudebrod research laboratories. The process makes it possible to produce a suture 20 per cent stronger than was formerly possible, according to the manufacturer's report. Champion Hi-Q Silk Sutures are almost twice as strong as U.S.P. standards and have exceptionally good qualities of smoothness and "hand." They are available in all colors and in a complete range of sizes, sterilized or unsterilized. **Gudebrod Bros. Silk Co., Inc., 225 W. 34th St., New York 1.**

For more details circle #827 on mailing card.

Planning Service for Housing Facilities

Plans for nurses homes and other resident housing, as well as the functional.



sturdy and attractive furniture, much of which can be incorporated into the room or suite structure so as to include it in the financing, are combined in a service developed by Sligh Lowry. Special considerations are taken into account in the furniture, which is built on certain constants, while other requirements are regarded as minimums. Included in the furniture line are desks, chests or dressers, wardrobes, storage cabinets, book shelves, beds, towel units, chairs and night stands or lamp tables. All of the furniture is designed for adapting to the need of each institution under consideration. **Sligh Lowry Furniture Co., Holland, Mich.**

For more details circle #828 on mailing card.

Plastic Protective Covers in Perforated Roll Form

Poly-Con Utility Protector is a tubular plastic material in perforated roll form. The 21 by 30-inch tubular cover, 200 to the roll, is pulled out and torn off for use as pillow protectors, specimen bags, laundry bags, waste receptacle liners, blanket protectors or for holding patients clothes. The roll may be hung on a wall or linen cart ready for immediate use, and the protective material is of special value for use in isolation wards, receiving and emergency rooms. **Continental Hospital Industries, Inc., 18624 Detroit Ave., Cleveland 7, Ohio.**

For more details circle #829 on mailing card.

(Continued on page 252)

Swinging-Door Cabinet in 42-inch Height

An addition to the line of swinging-door cabinets developed by Borroughs is offered in the new 42-inch high model. The cabinet has the same features as the 78-inch high model now on the market, with the doors swinging completely open for full accessibility. Shelves are adjustable on two-inch centers without tools, nuts or bolts. **Borroughs Mfg. Co., 3002 N. Burdick, Kalamazoo, Mich.**

For more details circle #830 on mailing card.

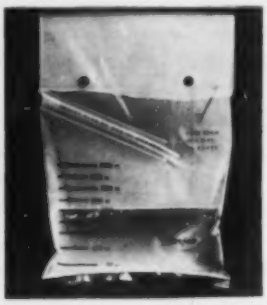
Two Chicken Soup Mixes Packaged for Institutions

A variety of chicken dishes and chicken flavored soups, sauces and gravies can be made with the two new products introduced by Continental. WB Chicken Soup Mix with the natural flavor derived from pure rendered chicken fat, and Real Chicken Soup Mix with more than 35 per cent roasted chicken meat, are both packed in wide mouth jars. **Continental Coffee Co., 2550 Clybourn, Chicago 14.**

For more details circle #831 on mailing card.

Larjan Plastic Drainage Bag Includes Sterile Tubing

Time, effort and costs are saved in purchase and storage with the new Larjan Plastic Drainage Bag which is a complete unit, including sterile tubing. Ready to use, the bag is easily snapped onto any hospital bed, litter or wheel chair, or tied to the patient's leg when ambulatory. With the sterile tubing already inserted in the drainage bag, contamination is avoided and the tube cannot pull out of the bag or fall into the drainage. For use, the catheter is simply joined to the tubing. The bag is made of heavy-gauge plastic for use during the entire period a patient requires drainage, and may then be discarded so that each patient has a new unit. The bag remains square when hanging, making the measurements, in bold black lettering, easy to read. The plastic bag will not stain or become offensive in use, and is easily emptied. **Hospital Supply & Development Co., 3109 Forbes Ave., Pittsburgh 13, Pa.**



For more details circle #832 on mailing card.

Space-maker Telephone Has Movable Dial and Hookswitch

A dial mounting that can be rotated a full 360 degrees, tilted backward 45 degrees and locked into place at any point, plus a handset cradle that swings in a 180-degree arc and locks into any one of seven different positions, make the new Space-Maker Telephone a versatile instrument for installation in many areas. Developed by General Telephone Laboratories, the new telephone has a clear plastic shield inside the base that ensures that wires and springs of the movable hookswitch will not become tangled when the installer changes the position of the cradle. A variety of mounting and wiring holes in the base permits easy mounting on desk, wall or any flat surface, or on an outlet box. **Automatic Electric, Sub. of General Telephone & Electronics, Wolf Rd. & North Ave., Northlake, Ill.**

For more details circle #833 on mailing card.

(Continued on page 254)

MAKING POSITIVE PHOTOCOPIES?

Save time, labor, and materials with the new PHOTOSTAT® Positive Process

Here's a new process that does in one step what you used to do in two.

The Photostat Positive Process completely skips the negative step and provides direct positive prints. As a result, you save considerable time, labor and material.

Does many jobs. Besides being a most efficient producer of positive prints, the Photostat Positive Process will do everything any office copier will do. Still more . . . it will even make enlargements and reductions.

Serves many fields. Any organization now using a multi-machine copying installation would be smart to look into the Photostat Positive Process. Banks find it useful in recording signatures. Insurance companies, schools, oil companies, and other industries find it a fast way to get positive copies.

For an analysis of your reproduction costs and methods, contact your nearest Photostat Corporation sales office. A representative will be glad to advise you on the procedures best suited to your particular needs.

®Registered Trademark of Photostat Corporation

PHOTOSTAT CORPORATION MEANS ALL THESE...

PROJECTION PHOTOCOPYING equipment and supplies
OFFSET DUPLICATING equipment and supplies
PROCEDURAL MICROFILMING equipment and supplies
OFFICE COPYING equipment and supplies

PHOTOSTAT CORPORATION
ROCHESTER, NEW YORK
A SUBSIDIARY OF Itek CORPORATION

Vacuum Bottle Trap Units Have Variety of Mountings

The new Ohio vacuum bottle trap units are available with a variety of mountings. The wall mounted units, with or without the vacuum regulator and gauge for mounting at eye level, are attached to a bracket which fastens directly to the wall, or may be used with a wall mounted slide. Three conductive rubber casters make the floor carrier model safe and easy to use and the bottle is held firmly by three rubber spacers. The bottle is easily removed for cleaning since regulator and gauge are separate from the bottle and cap assembly. All metal parts are corrosive resistant or chrome plated. **Ohio Chemical & Surgical Equipment Co., 1400 E. Washington Ave., Madison 10, Wis.**

For more details circle #834 on mailing card.

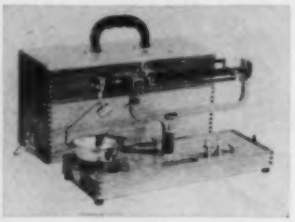
Automatic Flaked Ice Machine in Mobile Type Unit

The Ross-Temp Roll-O-Matic is a combination roll-away bin with a choice of three capacities of continuous flow flaked ice machines. The Roll-O-Matic insulated storage bin rolls under the ice machine which shuts off automatically when the cart is removed. The filled bins are then rolled to floor stations, kitchens and other areas where the ice is used. Bin capacity is 250 pounds of flaked ice, and ice machines are available in capacities of 150, 250 and 500 pounds in 24 hours. **Ross-Temp, Inc., 1805 S. 55th Ave., Chicago 50.**

For more details circle #835 on mailing card.

Portable Balance for Laboratory Use

A portable balance is now available in the Ohaus line of laboratory balances



and weights. Contained in an attractive and sturdy mahogany case, the balance can be used by merely removing the case top. It is sensitive to 10 milligrams and has a capacity of 311 grams with two 100-gram attachment weights. **Ohaus Scale Corp., 1050 Commerce Ave., Union, N.J.**

For more details circle #836 on mailing card.

Pharmaceuticals

Velacycline

A new and improved form of the versatile broad spectrum antibiotic, tetracycline, is available in Squibb Velacycline. Offered in both intramuscular and intravenous forms, the product is infinitely more soluble than ordinary tetracycline, making Velacycline Intravenous unusually well adapted for intravenous therapy. Peak blood levels which remain consistently higher over a 24-hour period are achieved with Velacycline Intramuscular. **E. R. Squibb & Sons, 745 Fifth Ave., New York 22.**

For more details circle #837 on mailing card.

Cosa-Terrabon and Cosa-Tetrabon

Cosa-Terrabon and Cosa-Tetrabon Oral Suspension and Pediatric Drops containing glucosamine, are homogeneous, orange-flavored, stable mixtures designed for palatability and ease of administration to infants, children, elderly or debilitated patients, or others who may have difficulty swallowing capsule medication. They are indicated for the antibiotic treatment of a wide variety of common infections or diseases caused by susceptible organisms. The addition of glucosamine, a natural substance in man, produces higher, faster and more consistently elevated antibiotic blood levels through increased absorption of the antibiotic from the gastrointestinal tract. **Pfizer Laboratories, 800 Second Ave., New York 17.**

For more details circle #838 on mailing card.

(Continued on page 256)

Add **AUDIO** easily

to your present

VISUAL nurse call system

of corridor domelights

Executone's DEPENDABLE Audio-Visual Nurse Call System Cuts Foot Travel in Half!

Easily and quickly added to your present visual domelight system, Executone frequently uses *existing* conduits or raceways—providing you with a *modern* Audio-Visual Nurse Call System! All accomplished with no interruption of service during installation!

Many hospitals—old and new—are discovering the economy and efficiency of Executone's Audio-Visual system. More patients are handled with *less effort, in less time!* One hospital reports that Executone has reduced operating costs 8% per bed. *It is an invaluable aid in relieving the nurse shortage.*

By pressing a bedside button, the patient activates signals at three locations—chime and light on nurse's control station, corridor domelight, buzzer and light on duty stations. The nurse presses key to reply . . . Executone's Call System may be installed complete, added to existing domelight systems, or installed without domelights.

Just off the press!

"Better Patient Care"

How Executone communications help hospitals improve patient care and make maximum use of nursing time and skills. Includes a summary of time and motion studies of Executone Audio-Visual Nurse Call Systems made by the Surgeon Generals' offices of the Army and Air Force. Also described and illustrated are Doctors' Paging Systems, Bedside Radio-Sound Systems, Departmental Administrative Systems. Send in the coupon below for your complimentary copy.

Executone

HOSPITAL COMMUNICATION SYSTEMS

MAIL COUPON TODAY!

EXECUTONE, INC., Dept. M-2 415 Lexington Ave., New York 17, N.Y.
Without obligation, please send me a complimentary copy of "Better Patient Care."

Name_____ Title_____

Hospital_____

Address_____

City_____ State_____

In Canada: 331 Bartlett Avenue, Toronto

Panwarfin

Panwarfin is a synthetic anticoagulant of uniform potency for the prevention and treatment of intravascular thrombosis and embolism. Stable oral dosage can be established with relative simplicity and predictable effects. The product is a member of the coumarin group of drugs that act as prothrombin depressants, concerned with the first stage of clotting in which prothrombin is converted to thrombin. It can be combined with Panheprin to initiate treatment and achieve immediate anticoagulant effect. Panwarfin is supplied in 5, 10 and 25 mg. tablets. **Abbott Laboratories, North Chicago, Ill.**

For more details circle #839 on mailing card.

Decagesic

Decagesic is a new product for the suppression of inflammation and the relief of pain in the long range control of mild rheumatic and arthritic disorders, for maintenance or tapering-off therapy and for other inflammatory conditions in which the conjunctive use of a steroid and salicylate can be beneficial. It combines the effective corticosteroid, Decadron, in low dosage, with aspirin, and the addition of aluminum hydroxide to help alleviate gastric irritation that may be caused by the aspirin. **Merck Sharp & Dohme, Div. of Merck & Co., Inc., West Point, Pa.**

For more details circle #840 on mailing card.

Ursinus Inlay-Tabs

Ursinus, for administration in the treatment of Sinus Symptom Complex, is the first product marketed as an Inlay-Tab, a new development for medication which consists of a recessed outer shell into which is laid a smaller tablet. The white outer shell of Ursinus contains Calurin, a freely soluble, well tolerated, neutral salt of aspirin to relieve pain, while the yellow inlay portion is of Triaminic, an oral nasal decongestant to promote sinus drainage. The Inlay-Tab technic of a tablet within a tablet can be applied to either capsule-shaped or round pills, and permits the combining of two components that may be incompatible to each other in a mixed granulation. Timed-release or sustained-release medication is also effective in Inlay-Tab, with either section of the tablet providing an immediately available amount of the medication while the other part contains the timed or sustained-release portion. **Smith-Dorsey Co., Div. the Wander Co., 233 S. Tenth St., Lincoln 1, Neb.**

For more details circle #841 on mailing card.

Analexin

A new class of drug that is both a general non-narcotic analgesic and an effective muscle relaxant is introduced as Analexin. It produces analgesia by raising the pain threshold and thus decreasing the perception of pain, and produces muscle relaxation by selectively depressing brain stem and spinal polysynaptic transmission. It is effective in the treatment of a wide variety of painful conditions, and is valuable in acute and chronic conditions where both pain and muscle spasm are involved. **Irwin, Neisler & Co., 401 N. Morgan, Decatur, Ill.**

For more details circle #842 on mailing card.

Topasil Silicone Skin Protectant

Topasil, an inert, greaseless formulation of pure silicone, seals skin from the irritating effects of abrasion, perspiration and fluids. Supplied in three-ounce sterile aerosol spray cans, it may be used on incontinent and invalid patients, colostomy and ileostomy cases and for diaper rash. **American Cyanamid Co., Surgical Products Div., 1 Casper St., Danbury, Conn.**

For more details circle #843 on mailing card.

Literature and Service

• Aimed at increasing the efficiency of the dishwashing department to make the best use of employes, especially in view of increasing wage costs, Economics Laboratory, Inc., 250 Park Ave., New York 17, offers several management and employe **four-color sound films for institutional food service.** The films, some in both Spanish and English, cover managerial and employe training; proper layout and flow pattern of the dishroom area; proper selection of dishes; proper usage and dispensing of detergents and drying agents, and proper selection of equipment.

For more details circle #844 on mailing card.

• An attractive 88-page catalog illustrates the line of **fine wood furniture** available from Thonet Industries, Inc., One Park Ave., New York 16. The furniture shown is specifically designed and engineered for use in schools, colleges, hospitals and other institutions, and includes a full line of tables, chairs, sectional units, desks, storage cabinets, stools and other items. Detailed information on the careful construction of the furniture is included in **Catalog 5801,** together with photographs of installations.

For more details circle #845 on mailing card.

• The complete line of **Onan Gasoline Driven Electric Plants** is listed in a new folder offered by D. W. Onan & Sons Inc., 2515 University Ave. S. E., Minneapolis 14, Minn. Information on the compact, self-contained generator sets covers their use for primary power, standby power or for portable or mobile power.

For more details circle #846 on mailing card.

• **"Integrity: The Story of Quality Control,"** is the title of an informative brochure published by Schering Corporation, Bloomfield, N.J., in conjunction with the opening of its new two-story building for the scientific control of quality in the production of pharmaceuticals. Every scientific function needed to ensure purity and superior quality of all products manufactured by the company is built into the new facility.

For more details circle #847 on mailing card.

• A new eight-page catalog, **"Faultless Hospital Casters" (Form No. 11159),** illustrates and describes the sixteen different types of casters manufactured for hospitals by Faultless Caster Corp., Evansville 7, Ind.

For more details circle #848 on mailing card.

• Designs embossed in architectural porcelain enamel on steel for architectural use are pictured in a folder entitled **"Sculpturama"** available from Davidson Enamel Products, Inc., 1104 E. Kibby, Lima, Ohio.

For more details circle #849 on mailing card.

(Continued on page 258)

• The line of **fire alarm systems** manufactured for hospitals and other institutions by the Standard Electric Time Co., 89 Logan St., Springfield, Mass., is covered in a new 36-page two-color catalog which includes information on the company's "March Time," master coded and box coded systems. Components and accessory equipment are illustrated and described, and typical job specifications are mentioned in the catalog.

For more details circle #850 on mailing card.

• Hospital equipment **"Designed to Meet Your Problems"** is the subject of an eight-page catalog published by E. F. Brewer Co., Butler, Wis. Included are data and illustrations on commode curtains, autoclave stands, bed rails, kick bucket stands, solution bowl stands, screens and the like.

For more details circle #851 on mailing card.

• **Edition 46** of the catalog of **Ellison Balanced Doors** is now available from Ellison Bronze Co., Inc., Jamestown, N.Y. The 12-page brochure gives specifications, drawings of construction details, and photographs of actual installations.

For more details circle #852 on mailing card.

Book Releases

Harrow, Borek, Mazur, Stone and Wagreich, "Laboratory Manual of Biochemistry," 5th ed., 169 pgs., $3.25. Frobisher and Sommermeyer, "Microbiology for Nurses," 10th ed., 562 pgs., $5. Frobisher, Sommermeyer and Goodale, "Microbiology and Pathology for Nurses," 5th ed., 888 pgs., $7.50. McClain, "Simplified Arithmetic for Nurses," 2nd ed., 150 pgs., $2. **W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa.**

For more details circle #853 on mailing card.

Payne and Callahan, "Low Sodium, Fat-Controlled Cook Book," published by Little, Brown & Co. Special paper back edition available at $1.50 from **Sunkist Growers, Sec. 9, Box 2706, Terminal Annex, Los Angeles 54, Calif.**

For more details circle #854 on mailing card.

Suppliers' News

The DuBois Co., Inc., 1120 W. Front St., Cincinnati 3, Ohio, manufacturer of cleaning compounds, announces the introduction of **"Mr. Du,"** a new trade character for use in advertising and promotions to represent its sales force of over 500 men throughout the United States, Canada and Latin America. Developed as part of its 40th anniversary promotions, **"Mr. Du"** has a halo which repeats the oval shape and accent mark of the trade mark recently adopted by the company.

The Grover Company, 25525 W. Eight Mile Rd., Detroit 40, Mich., manufacturer of **Grover Transitube Pneumatic Tube Systems** for hospitals and other institutions, has become a subsidiary of **Powers Regulator Company, Skokie, Ill.,** manufacturer of automatic temperature controls and equipment. The management of **The Grover Company** remains the same, according to the report, and business will continue with the same policies and quality manufacture, but marketing efforts and product scope will be greatly expanded.

Shampaine Industries, Inc., 1920 S. Jefferson, St. Louis 4, Mo., announces the formation of Shampaine Scientific Co. with headquarters at 615 E. First Ave., Roselle, N.J. The new subsidiary will market laboratory and scientific equipment for health and educational institutions and will have two factories, one in St. Louis, Mo. and the other in Roselle, N.J.

L. Sonneborn Sons, Inc., 404 Fourth Ave., New York 10, manufacturer of building and maintenance specialties, lubricants and chemicals, announces change of corporate name to **Sonneborn Chemical & Refining Corporation.** A new company-developed symbol will also be used on all corporate material of the company.

West Chemical Products, Inc., 42-16 West St., Long Island City 1, N.Y., manufacturer of chemical specialty products for environmental sanitation, announces acquisition of the business assets and good will of the **Vitarine Company, Inc., New York,** and its subsidiaries in the field of manufacturing, packaging and distribution of drugs and allied products. The purchase represents an expansion by West into a closely allied field. The report states that West intends to continue the business and policies of **Vitarine** without change and the management of **Vitarine** will continue active participation in their present capacities.

INDEX TO ADVERTISEMENTS

USE THIS PAGE TO REQUEST PRODUCT INFORMATION

The index on this and the following page lists advertisements in this magazine alphabetically by manufacturer. For additional information about any product or service advertised, circle the manufacturer's key number on the detachable postcard and mail it. No postage is required.

Products described in the "What's New" pages of this magazine also have key numbers which appear in each instance following the description of the item. For more information about these items, circle the appropriate numbers on the postcard and mail it, without postage, to The Modern Hospital.

(continued on next page)

USE THIS CARD — (We pay the postage)

I am interested in the items circled— **May, 1960**

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INSTITUTION _____

ADDRESS _____ ZONE _____ STATE _____

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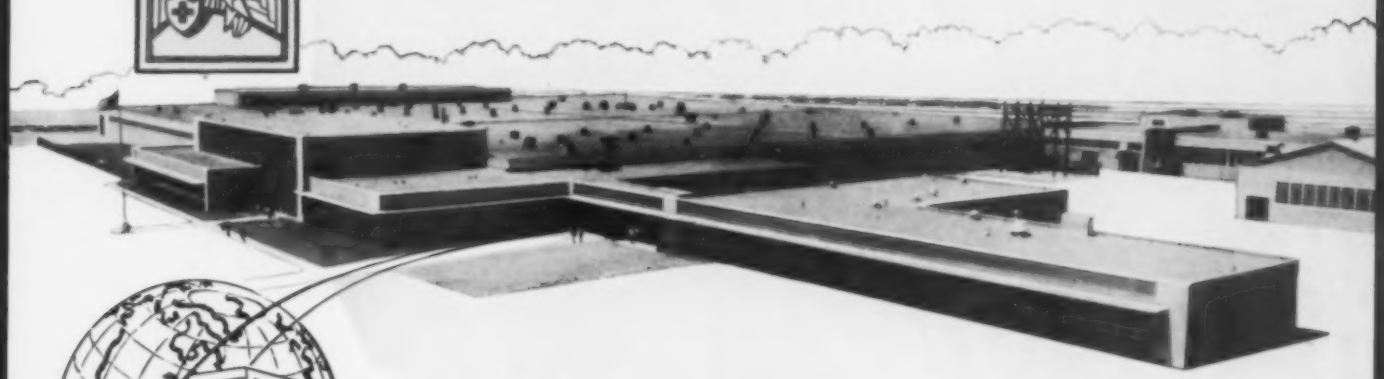
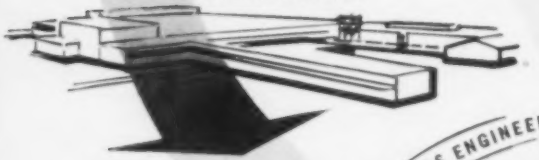
Procedure

for CENTRAL SERVICE EFFICIENCY



AMSCO RESEARCH LABORATORIES



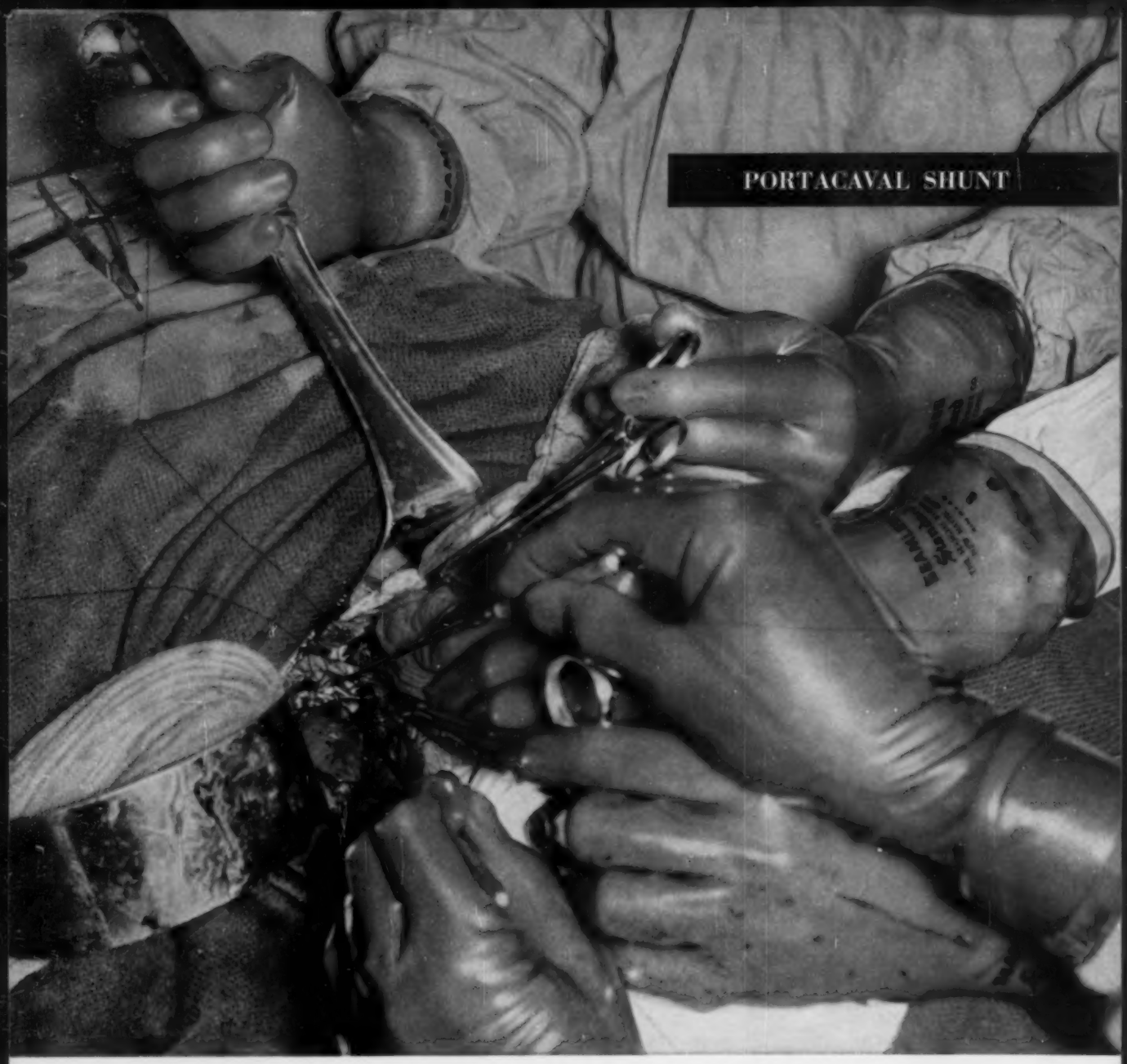
To improve the efficiency of a good Central Service Department . . . or to assure maximum performance for a new one . . . **talk to the most discontented people in the world!**

You'll find them in the professional staffs of the American Sterilizer Research and Technical Projects Divisions . . . working with the hospital problems and methods from more than a hundred countries. Their unrest stems from a steadfast unwillingness to accept any technical problem as unsolvable, or any improvement as **final.** This enlightened dissatisfaction sparks a continuing development of advanced techniques and equipment to help hospital technical departments do **better** work, **easier** and at **less cost.**

Because its function is so broadly vital to hospitals, the Central Service Department enjoys exceptional benefits from Amsco's dedication to "the better way." The Amsco concept assures an integrated technic of the highest order, in which each detailed procedure flows smoothly to the next . . . for the ultimate in patient protection, and the maximum utilization of space, personnel and equipment.

Write for illustrated brochure MC-506 "The Central Service Department."

AMERICAN STERILIZER
ERIE • PENNSYLVANIA



Make the Surgeon's Task Easier

Brown Milled Surgeons' Gloves by SEAMLESS

Before you order surgical gloves again, consider these facts. Deep in an incision, the maximum tactile sensitivity of Brown Milled Surgeons' Gloves by Seamless assure unmatched "sightless seeing." Minimal radial bind across the knuckles and palm guarantees maximum comfort. Equally important, their hypoallergenic property eliminates the possibility of latex dermatitis. These advantages make Brown Milled Gloves the finest general surgeon's glove available today. Contact your Seamless representative for further information and samples.

HOSPITAL DIVISION

THE SEAMLESS RUBBER COMPANY

NEW HAVEN 3, CONN., U.S.A.